| Health Financi | al Systems | WABASH COUNTY HO | SPTTAI | Tn Lie | u of Form CMS-2552-10 |
|------------------------|--|--|--|--|--|
| This report is | s required by law (42 USC 1395g; since the beginning of the cost | 42 CFR 413.20(b)). Falur | re to report can re | esult in all interim | FORM APPROVED |
| | HOSPITAL HEALTH CARE COMPLEX COST | | Provider CCN: 151 | | Worksheet S Parts I-III |
| PART I - COST | The state of the s | The second secon | | | |
| Provider use only | [X] Electronically filed cost 2. [] Manually submitted cost 3. [0] If this is an amended re 4. [F] Medicare Utilization. En | report Poort enter the number o | f times the provide for low. | Date:5/29/20 er resubmitted this c | |
| Contractor use only | (1) As Submitted 7. (2) Settled without Audit 8. | | this Provider CCN | | or Code: 4 Plumn 1 is 4: Enter les reopened = 0-9. |
| DART WT | | | er senter anno e conservamente sentente e conservamente e conquera a conquera que que de la conservamente de l | The second secon | |

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WABASH COUNTY HOSPITAL (151310) for the cost reporting period beginning 01/01/2012 and ending 12/31/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 5/29/2013 Time: 9:23 am Hj4dabuRW:djGq3sSWd.y2TSGLQ:e0 6wcIt0ax8cAL2sAMhcnODUovTs8gUf UTT50obkLN0w.bl1

PI: Date: 5/29/2013 Time: 9:23 am AW80GjMawAoDqD7nkz17Qc71.YDLb0 EqSNW0cZixouQGAACw9ntPN161H:E2 ze2k0es36R0tMdhI

(Signed)

officer or Administrator of Provider(s)

Date

| | | | Title: | XVIII | | The second secon | T |
|--------|--|----------------|-----------------|------------------|--------------|--|--------|
| | | Title V | Part A | Part B | HIT | Title XIX | |
| | TATELAN Address Statement Statement (Statement Statement | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | PART III - SETTLEMENT SUMMARY | | | | | | |
| 1.00 | Hospital | ol | -261.932 | -354.951 | 89,966 | | 1.00 |
| 2.00 | Subprovider - IPF | o | 0 | 001,002 | 05,500 | 0 | 2.00 |
| 3.00 | Subprovider - IRF | 0 | ň | 0 | İ | 0 | |
| 4.00 | SUBPROVIDER I | ŏ | 0 | 0 | | 0 | 3.00 |
| 5.00 | Swing bed - SNF | 0 | -28,332 | 0 | | U | 4.00 |
| 6.00 | Swing bed - NF | | -26,332 | V _I | | 0 | 5.00 |
| 7.00 | SKILLED NURSING FACILITY | | ما | | | 0 | 6.00 |
| 8.00 | NURSING FACILITY | 0 | o _l | U | | 0 | 7.00 |
| 9.00 | HOME HEALTH AGENCY I | | | | | 0 | 8.00 |
| 10.00 | RURAL HEALTH CLINIC I | 0 | U | 0 | | 0 | 9.00 |
| 11.00 | | U | | 0 | | 0 | 10.00 |
| 12.00 | The state of the s | 0 | | 0 | | 0 | 11.00 |
| | | 0 | | 0 | | 0 | 12.00 |
| | Total | 0 | -290,264 | -354,951 | 89,966 | 0 | 200.00 |
| ine ar | ove amounts represent "due to" or "due from" | the applicable | program for the | e element of the | ahove comple | v indicated | |

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

MCRIF32 - 3.14.141.0

| Health Financ | rial Systems | WABASH COUNTY H | OSBITAL | | To 1 do | of Form CM5 | 2552 44 |
|--|---|--|--|--|---|---|-----------|
| This report payments mad | is required by law (42 USC 1395g; 4 e since the beginning of the cost r | 2 CFR 413.20(b)). Fall reporting period being | ure to repo | rt can result | in all interim | u of Form CMS FORM APPROVE OMB NO. 0938 | D |
| HOSPITAL AND AND SETTLEME | HOSPITAL HEALTH CARE COMPLEX COST NT SUMMARY | REPORT CERTIFICATION | | CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S Parts I-III | epared: |
| Provider | T REPORT STATUS | The state of the s | | management of the second of th | | | |
| use only | 1.[X]Electronically filed cost of a submitted | report | of times th "_for low. | e provider re | Date: 5/29/20 submitted this c | | 9:23 a.m |
| Contractor use only | (1) As Submitted 7. C (2) Settled without Audit 8. [| ate Received: ontractor No. N]Initial Report fo N]Final Report for | r this Prov this Provid | ider CCN 12.[| | or Code: olumn 1 is 4: nes reopened = | |
| PART II - CEI | RTIFICATION ATION OR FALSIFICATION OF ANY INFOR | | · · · · · · · · · · · · · · · · · · · | | | | |
| ADMINISTRATIV | /E ACTION, FINE AND/OR IMPRISONMENT PROCURED THROUGH THE PAYMENT DIRECT /E ACTION, FINES AND/OR IMPRISONMEN CERTIFICATION BY OFFICER OR AD REBY CERTIFY that I have read the a tronically filed or manually submit uses prepared by WABASH COUNTY HOSE | LY OR INDIRECTLY OF A T MAY RESULT. MINISTRATOR OF PROVIDE bove certification stated cost report and the | KICKBACK OF R(S) atement and he Balance | R WERE OTHERW: that I have | EXAMINED THE ACC | MINAL, CIVIL A | KE AND |
| comp excel healt laws <u>Encry</u> ECR: | ng 12/31/2012 and to the best of my lete and prepared from the books and the services, and that the services and regulations. //ption Information Date: 5/29/2013 Time: 9:23 am abuRW:djGq3sSwd.y2TSGLQ:e0 | d records of the provi t I am familiar with i | ider in acco the laws and is cost repo | ordance with d regulations ort were prov | applicable instr | uctions, rovision of ce with such | |
| | OaX8cAL2sAMhcnODUovTs8quf | | | | | | |
| PI: AW800 | ObkLNOw.bLl Date: 5/29/2013 Time: 9:23 am ijMawAoDqD7nkzl7Qc71.YDLbO |] | Title | | | | |
| | /OcZixouQGAACw9ntPN161H:E2 Des36ROtMdhI | | Date | | | | |
| | | Title V | Title Part A | Part B | | -247 | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | Title XIX 5.00 | + |
| | I - SETTLEMENT SUMMARY | The second secon | | | | | 1 |
| 1.00 Hospita 2.00 Subpro | al vider – IPF | 0 | -261,932 | , | | C | 1.00 |
| | vider - IRF | 0 | 0 | | 0 | | |
| 4.00 SUBPRO | /IDER I | 0 | 0 | | 0 | 0 | |
| | ped - SNF | Ö | -28,332 | | 0 | 0 | |
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| | EALTH AGENCY I | 0 | | | | 0 | 0.00 |
| i i | HEALTH CLINIC I | O O | 0 | | | 0 | |
| 11.00 FEDERAL | LY QUALIFIED HEALTH CENTER I | 0 | | | | 0 | |
| 12.00 CMHC I | | o o | | | o l | 0 | |
| Z00.00 Total | Units nonmonant Habitation III | 0 | -290,264 | ~354,95 | 89,966 | _ | 200.00 |
| According to | unts represent "due to" or "due fro | om the applicable pro | gram for th | e element of | the above comple | | |
| displays a va | the Paperwork Reduction Act of 1999 lid OMB control number. The valid | o, no persons are requ | ired to res | pond to a col | lection of infor | mation unless | it |

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

| Healt | h Financial Systems WABASH COUNTY HOS | PITAL | | I | n Liei | u of For | m CMS- | -2552-10 |
|-------|--|------------------------|--|--|---------|---|---------|------------|
| HOSPI | TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider | | Period: | | Worksh | | |
| | | | | From 01/01 To 12/31 | | Part I Date/T | ima Bra | anarad: |
| | | | and the second s | , | | 5/29/20 | | |
| | | | | Beginn | | Endi | | |
| 36.00 | Enter applicable beginning and ending dates of SCH status. Subsc | rint line | 36 for numbo | 1.00 |) | 2.0 | 00 | 36.00 |
| | OT periods in excess of one and enter subsequent dates | | | i | i | | | 36.00 |
| 37.00 | If this is a Medicare dependent hospital (MDH), enter the number | of perio | ds MDH status | | o | | | 37.00 |
| 38.00 | in effect in the cost reporting period. Enter applicable beginning and ending dates of MDH status. Subsc | | 20 6 | | | | | |
| | of periods in excess of one and enter subsequent dates. | ript line | e 38 for numbe | r | | | | 38.00 |
| | | | | Y/N | | Υ/ | 'n | + - |
| 30 00 | Door the facility personially will for | | | 1.00 |) | 2.0 | | |
| 33.00 | Does the facility potentially qualify for the inpatient hospital volume hospitals as deemed by CMS according to the Federal Regis "Y" for yes or "N" for no. Additionally, does the facility meet requirements in accordance with 42 CFR 412.101(b)(2)? Enter in C | ter? Ent | er in column : | | | N | | 39.00 |
| | "N" for no. | | To the contract of the contrac | | I | | 1 | |
| | | | | | V | XVIII | | |
| | Prospective Payment System (PPS)-Capital | | ** *** *** *** *** *** *** *** *** *** | or the database of a second control of a secon | 1.00 | 2.00 | 3.00 | |
| 45.00 | Does this facility qualify and receive Capital payment for dispri | oportiona | te share in a | cordance | N | N | N | 45.00 |
| 46.00 | with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for e | | | | | | | |
| | pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Pa | xtraordin rt TTT an | ary circumsta dil-1 Parts | 1ces C through | N | N | N | 46.00 |
| 47.00 | 111. | | | | | | | |
| 47.00 | Is this a new hospital under 42 CFR §412.300 PPS capital? Enter | "Y for y | es or "N" for | no. | N | N | N | 47.00 |
| 10.00 | Is the facility electing full federal capital payment? Enter "Y' Teaching Hospitals | " for yes | or "N" for no |) | N | N N | N | 48.00 |
| 56.00 | Is this a hospital involved in training residents in approved GMI | E program | s? Enter "Y" | for ves | N | 1 | 1 | 56.00 |
| | OF N FOR NO. | | | | ," | | | 30.00 |
| 37.00 | If line 56 is yes, is this the first cost reporting period during GME programs trained at this facility? Enter "Y" for yes or "N" is "Y" did residents at the first cost reporting period during "Y" for yes or "N" | g which r | esidents in ap | proved | | | ĺ | 57.00 |
| | is i did residents start training in the first month of this co | net ranar | ting pariad? | Entan "V" | | | | |
| | for yes or N for no in column 2. If column 2 is "v" complete | Warkshoo | t E-4. If colu | ımn 2 is | | | | |
| 58.00 | "N", complete worksheet D, Part III & IV and D-2, Part II, if application of the second of the secon | nlicabla | | | | | | |
| | wellined in CMS Pub. 15-1. Section /1487 It was complete workshop | 2+ 10-5 | | as | | | | 58.00 |
| 59.00 | Are costs claimed on line 100 of Worksheet A? If was complete w | Norkchaat | D-2, Part I. | | N | | | 59.00 |
| 60.00 | Are you claiming nursing school and/or allied health costs for a | program | that monte the | <u> </u> | N | | | 60.00 |
| | provider-operated criteria under §413.85? Enter "Y" for yes or ' | 'N" for n | | | l | <u></u> | | |
| | | | Y/N | IME Aver | rage | Direct | | |
| | | | 1.00 | 2.00 | | Aver: | | |
| 61.00 | Did your facility receive additional FTE slots under ACA section | 5503? | N | | 0.00 | | | 61.00 |
| | Enter "Y" for yes or "N" for no in column 1. If "Y", effective f portions of cost reporting periods beginning on or after July 1, | for | | | | | | |
| | lenter the average number of primary care FTF residents for TMF in | COLUMN | | | | | | |
| | 1/2 and direct GME in column 3, from the hospital's three most reco | nt cost | | | | | | |
| | reports ending and submitted before March 23, 2010 (see instruc | tions) | | | | | | |
| 62.00 | ACA Provisions Affecting the Health Resources and Services Admini Enter the number of FTE residents that your hospital trained in t | stration | | | | | | |
| | cost reporting period for which your hospital received HRSA PCRE | s fundina | 0.0 | U _j | | | i | 62.00 |
| 62 01 | (See instructions) | - | | | | | | |
| 52.01 | Enter the number of FTE residents that rotated from a Teaching He Center (THC) into your hospital during in this cost reporting per | alth | 0.0 | O | | | | 62.01 |
| | HKSA THE program. (see instructions) | 'lod of | | | | | | |
| C3 00 | Teaching Hospitals that Claim Residents in Non-Provider Settings | | | | | | | |
| 03.00 | Has your facility trained residents in non-provider settings duri | ng this | N | | | *************************************** | | 63.00 |
| | cost reporting period? Enter "Y" for yes or "N" for no in column yes, complete lines 64-67. (see instructions) | 1. If | | | 1 | | , | |
| | THE PARTY OF THE P | | Unweighted | Unweight | n har | atio (c | 01 1/ | |
| | | | FTES | FTES i | n (| col. 1 | + col. | |
| | | | Nonprovider | Hospita | al [| 2)) | | |
| | | | Site | 2 00 | | | | |
| | Section 5504 of the ACA Base Year FTE Residents in Nonprovider se | ttinas7 | 1.00 This base year | 2.00 | nc+ =- | 3.0 | U | |
| | | | Juse jear | .a your Ci | ost 1.6 | por cing | | |
| 34.00 | Enter in column 1, if line 63 is yes, or your facility trained re in the base year period, the number of unweighted non-primary car | cidente | 0.00 |) | 0.00 | 0.0 | 000000 | 64.00 |
| | resident FIES attributable to rotations occurring in all non-prov | idor | | | | | | |
| | settings. Enter in column 2 the number of unweighted non-primary | care | | | | | l | |
| | resident FIES that trained in vour hospital Enter in column 2 +b. | a natio | | | | | | |
| f | of (column 1 divided by (column 1 + column 2)). (see instructions |) | | | | | | |

| Health Financial Systems | WABASH (| COUNTY HOSPITAL | | | In Lie | u of Form CMS- | -2552-10 |
|--|------------------------|---------------------|---------------------|---------------------------|---|----------------|-------------------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLE | X IDENTIFICATION DATA | A Provider | CCN: 1513 | From 01 | From 01/01/2012 Part I | | repared: |
| [a7] | | | | | CONTRACT OF STREET AS A STREET, NAME AND A STREET, | 1.00 | |
| Multicampus 165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. | umpus hospital that ha | as one or more camp | ouses in d | ifferent CB | SAs? | N | 165.00 |
| | Name | County | State | Zip Code | CBSA | FTE/Campus | |
| | 0 | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 | | | | | | 0.0 | 0166.00 |
| | | | | | | 1.00 | |
| Health Information Technology (HIT |) incentive in the A | merican Recovery an | d Reinves | tment Act | | | |
| 167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H | 5 is "Y") and is a me | eaninaful user (lin | yes or "le 167 is " | N" for no. "Y"), enter | the | Y 1,017,88 | 167.00 0168.00 |
| 169.00 If this provider is a meaningful utransition factor. (see instruction | ser (line 167 is "Y") |) and is not a CAH | (line 105 | is "N"), e | nter the | 0.0 | 0169.00 |

| | TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE | STIONNAIRE Provider | | eriod: rom 01/01/2012 | Worksheet S-2 | 2 |
|--------------------------------------|--|---|---|----------------------------------|----------------------------------|--|
| | | | | o 12/31/2012 | | |
| | | | | Y/N | Date | Jo alli |
| | General Instruction: Enter Y for all YES resp | | | 1.00 | 2.00 | |
| | mm/dd/yyyy format. | ponses. Enter N for all NO P | esponses. Enter | all dates in | rue | |
| | COMPLETED BY ALL HOSPITALS | | | | | |
| .00 | Provider Organization and Operation Has the provider changed ownership immediate | ly prior to the beginning of | the cost | N N | T | 1. |
| | reporting period? If yes, enter the date of | | instructions) | | | |
| | | | Y/N 1.00 | Date 2.00 | 3.00 | |
| .00 | Has the provider terminated participation in | the Medicare Program? If | N N | 2.00 | 3.00 | |
| | yes, enter in column 2 the date of termination | on and in column 3, "V" for | | | | |
| .00 | voluntary or "I" for involuntary. Is the provider involved in business transac | tions, including management | N | | | 3. |
| | contracts, with individuals or entities (e.g | ., chain home offices, drug | | | | |
| | or medical supply companies) that are related officers, medical staff, management personne | d to the provider or its l or members of the board | | | | |
| | of directors through ownership, control, or | family and other similar | | | | |
| | relationships? (see instructions) | | | | Bad a | |
| | | | Y/N 1.00 | 7ype 2.00 | Date 3.00 | - |
| | Financial Data and Reports | | | 1 | | |
| .00 | Column 1: Were the financial statements pre Accountant? Column 2: If yes, enter "A" for | pared by a Certified Public | Y | С | 05/15/2012 | 4. |
| | or "R" for Reviewed. Submit complete copy or | enter date available in | | | | |
| 00 | column 3. (see instructions) If no, see inst | ructions. | | | | _ |
| 00 | Are the cost report total expenses and total those on the filed financial statements? If | | N | | | 5. |
| | | | | Y/N | Legal Oper. | |
| | Approved Educational Activities | | | 1.00 | 2.00 | + |
| 00 | Column 1: Are costs claimed for nursing sch | ool? Column 2: If yes, is t | he provider is | N | | 6. |
| 00 | the legal operator of the program? | 7 +6 808 instrument | | | | _ |
| 00 00 | Are costs claimed for Allied Health Programs were nursing school and/or allied health pro | | d during the | N N | | 8. |
| | cost reporting period? If yes, see instruction | ons. | • | | | |
| 00 | Are costs claimed for Intern-Resident program yes, see instructions. | ms claimed on the current co | st report? If | N | | 9. |
| .00 | Was an Intern-Resident program been initiated | d or renewed in the current | cost reporting | N | | 10. |
| | period? If yes, see instructions. | | | 1 | Ē | |
| . 00 | | re other than T & D in an An | nroved | l N | | 11 |
| | Teaching Program on Worksheet A? If yes, see | rs other than I & R in an Ap instructions. | proved | N | | 11. |
| | Teaching Program on Worksheet A? If yes, see | rs other than I & R in an Ap instruction <u>s</u> . | proved | N | Y/N | 11. |
| 1.00 | Teaching Program on Worksheet A? If yes, see Bad Debts | instructions. | | N | Y/N 1.00 | 11. |
| 2.00 | Bad Debts Is the provider seeking reimbursement for ba | instructions. d debts? If yes, see instruc | tions. | | 1.00 Y | 12. |
| 2.00 | Bad Debts Is the provider seeking reimbursement for ball of line 12 is yes, did the provider's bad delays to the provider's bad dela | instructions. d debts? If yes, see instruc | tions. | | 1.00 | 12. |
| 2.00 | Bad Debts Is the provider seeking reimbursement for bad if line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles are | instructions. d debts? If yes, see instruc bt collection policy change | tions. during this cos | t reporting | 1.00 Y | 12. |
| 2.00 | Bad Debts Is the provider seeking reimbursement for bail in 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement | instructions. d debts? If yes, see instruc bt collection policy change and/or co-payments waived? I | tions. during this cos f yes, see inst | t reporting | 1.00 Y N | 12. 13. 14. |
| .00 | Bad Debts Is the provider seeking reimbursement for bad if line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles are | instructions. d debts? If yes, see instruc bt collection policy change and/or co-payments waived? I | tions. during this cos f yes, see inst yes, see instr | t reporting | 1.00 Y N | 12. 13. |
| .00 | Bad Debts Is the provider seeking reimbursement for bail in 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement | instructions. d debts? If yes, see instruction policy change and/or co-payments waived? If or cost reporting period? If Description | tions. during this cos f yes, see inst yes, see instr Par Y/N | ructions. uctions. t A Date | 1.00 Y N N Part B Y/N | 12. 13. |
| .00 | Bad Debts Is the provider seeking reimbursement for bad If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles are Bed Complement Did total beds available change from the prior | instructions. d debts? If yes, see instruction policy change and/or co-payments waived? If or cost reporting period? If | tions. during this cos f yes, see inst yes, see instr | t reporting ructions. | 1.00 Y N N Part B | 12. 13. |
| .00 | Bad Debts Is the provider seeking reimbursement for bad If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles are Bed Complement Did total beds available change from the prior PS&R Data Was the cost report prepared using the PS&R | instructions. d debts? If yes, see instruction policy change and/or co-payments waived? If or cost reporting period? If Description | tions. during this cos f yes, see inst yes, see instr Par Y/N | ructions. uctions. t A Date | 1.00 Y N N Part B Y/N | 12. 13. 14. |
| .00 | Bad Debts Is the provider seeking reimbursement for bar If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles are Bed Complement Did total beds available change from the prior provider between the prior beds are period. PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, | instructions. d debts? If yes, see instruction policy change and/or co-payments waived? If or cost reporting period? If Description | tions. during this cos f yes, see inst yes, see instr Par Y/N 1.00 | ructions. uctions. t A Date 2.00 | 1.00 Y N N Part B Y/N 3.00 | 12. 13. 14. |
| .00 | Bad Debts Is the provider seeking reimbursement for bar If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles and Bed Complement Did total beds available change from the prior total beds available change from the prior Bed Complement PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R | instructions. d debts? If yes, see instruction policy change and/or co-payments waived? If or cost reporting period? If Description | tions. during this cos f yes, see inst yes, see instr Par Y/N 1.00 | ructions. uctions. t A Date 2.00 | 1.00 Y N N Part B Y/N 3.00 | 12. 13. 14. |
| .00 | Bad Debts Is the provider seeking reimbursement for bad If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prior total beds available change from the prior Ps&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the Ps&R Report used in columns 2 and 4 .(see instructions) | instructions. d debts? If yes, see instruction policy change and/or co-payments waived? If or cost reporting period? If Description | tions. during this cos f yes, see inst yes, see instr Par Y/N 1.00 | ructions. uctions. t A Date 2.00 | 1.00 Y N N Part B Y/N 3.00 | 12. 13. 14. |
| .00 | Bad Debts Is the provider seeking reimbursement for bad If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles and total beds available change from the prior bid total beds available change from the ps&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the ps&R | instructions. d debts? If yes, see instruction policy change and/or co-payments waived? If or cost reporting period? If Description | tions. during this cos f yes, see inst yes, see instr Par Y/N 1.00 | ructions. uctions. t A Date 2.00 | 1.00 Y N N Part B Y/N 3.00 | 12. 13. 14. 15. |
| .00 | Bad Debts Is the provider seeking reimbursement for bar If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles are Bed Complement Did total beds available change from the prior total beds available change from the prior was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report of totals and the provider's records for allocation? If either column 1 or 3 is | instructions. d debts? If yes, see instruction policy change and/or co-payments waived? If or cost reporting period? If Description | tions. during this cos f yes, see inst yes, see instr Par Y/N 1.00 | ructions. uctions. t A Date 2.00 | 1.00 Y N N Part B Y/N 3.00 | 12. 13. 14. 15. |
| 00 | Bad Debts Is the provider seeking reimbursement for bailf line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles and total beds available change from the prior total beds available change from the prior beds and the provider's period total beds available change from the prior total beds available change from the prior beds total beds available change from the prior total beds available change from the prior total beds available change from the ps&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the Ps&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns | instructions. d debts? If yes, see instruction policy change and/or co-payments waived? If or cost reporting period? If Description | tions. during this cos f yes, see inst yes, see instr Par Y/N 1.00 | ructions. uctions. t A Date 2.00 | 1.00 Y N N Part B Y/N 3.00 | 12. 13. 14. 15. |
| .00 | Bad Debts Is the provider seeking reimbursement for bailf line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles abed Complement Did total beds available change from the prior PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 .(see instructions) | instructions. d debts? If yes, see instruction policy change and/or co-payments waived? If or cost reporting period? If Description | tions. during this cos f yes, see inst yes, see instr Par Y/N 1.00 | ructions. uctions. t A Date 2.00 | 1.00 Y N N N Part B Y/N 3.00 Y | 12. 13. 14. 15. |
| .00 | Bad Debts Is the provider seeking reimbursement for bailf line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles and total beds available change from the priodid total beds available change from the ps&R Report used in columns 2 and 4 (see instructions) and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 (see instructions) If line 16 or 17 is yes, were adjustments made to Ps&R Report data for additional | instructions. d debts? If yes, see instruction policy change and/or co-payments waived? If or cost reporting period? If Description | tions. during this cos f yes, see inst yes, see instr Par Y/N 1.00 | ructions. uctions. t A Date 2.00 | 1.00 Y N N Part B Y/N 3.00 | 12. 13. 14. 15. |
| .00 | Bad Debts Is the provider seeking reimbursement for bailf line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles are been complement Did total beds available change from the prior been constructions) Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 . (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not | instructions. d debts? If yes, see instruction policy change and/or co-payments waived? If or cost reporting period? If Description | tions. during this cos f yes, see inst yes, see instr Par Y/N 1.00 | ructions. uctions. t A Date 2.00 | 1.00 Y N N N Part B Y/N 3.00 Y | 12. 13. 14. 15. |
| .00 | Bad Debts Is the provider seeking reimbursement for bailf line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles abed Complement Did total beds available change from the priod total beds available change from the Ps&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the Ps&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 (see instructions) If line 16 or 17 is yes, were adjustments made to Ps&R Report data for additional claims that have been billed but are not included on the Ps&R Report used to file this cost report? If yes, see instructions. | instructions. d debts? If yes, see instruction policy change and/or co-payments waived? If or cost reporting period? If Description | tions. during this cos f yes, see inst yes, see instr Par Y/N 1.00 | ructions. uctions. t A Date 2.00 | 1.00 Y N N N Part B Y/N 3.00 Y | 12 13 14. 15. |
| .000 | Bad Debts Is the provider seeking reimbursement for bailf line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles abed Complement Did total beds available change from the prior total beds available change from the prior propert only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 .(see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments | instructions. d debts? If yes, see instruction policy change and/or co-payments waived? If or cost reporting period? If Description | tions. during this cos f yes, see inst yes, see instr Par Y/N 1.00 | ructions. uctions. t A Date 2.00 | 1.00 Y N N N Part B Y/N 3.00 Y | 12. 13. 14. 15. 16. |
| .00 | Bad Debts Is the provider seeking reimbursement for bailf line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles and total beds available change from the priod total beds available change from the ps&R Report used in columns 2 and 4 (see instructions) was the cost report prepared using the Ps&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 (see instructions) If line 16 or 17 is yes, were adjustments made to Ps&R Report data for additional claims that have been billed but are not included on the Ps&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to Ps&R Report data for corrections of | instructions. d debts? If yes, see instruction policy change and/or co-payments waived? If or cost reporting period? If Description | tions. during this cos f yes, see inst yes, see instr Y/N 1.00 Y | ructions. uctions. t A Date 2.00 | N N Part B Y/N 3.00 | 12. 13. 14. 15. 16. |
| .000 | Bad Debts Is the provider seeking reimbursement for bailf line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles are been complement Did total beds available change from the prior been considered as a provider beautifulation. The considered as a provider beautifulation and conside | instructions. d debts? If yes, see instruction policy change and/or co-payments waived? If or cost reporting period? If Description | tions. during this cos f yes, see inst yes, see instr Y/N 1.00 Y | ructions. uctions. t A Date 2.00 | N N Part B Y/N 3.00 | 12. 13. 14. 15. 16. |
| 3.00 3.00 3.00 3.00 3.00 | Bad Debts Is the provider seeking reimbursement for bailf line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles are bed Complement Did total beds available change from the prior bed to see instructions) Was the cost report prepared using the PS&R Report used in columns 2 and 4. (see instructions) if either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) if line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see | instructions. d debts? If yes, see instruction policy change and/or co-payments waived? If or cost reporting period? If Description 0 | tions. during this cos f yes, see inst yes, see instr Y/N 1.00 Y | ructions. uctions. t A Date 2.00 | N N Part B Y/N 3.00 | 11. 12. 13. 14. 15. 16. 17. 18. |

| HOSPITAL AND | HOSPITAL HEALTH CARE REIMBURSEMENT QUE | STIONNAIRE | | rovider C | CCN: 151310 | Period: From 01/01/201 To 12/31/201 | | epared: |
|----------------------------|---|----------------------------------|----------------------|--|-------------|---|----------------|----------------|
| | | Desci | ription | | Y/N | Date | Y/N | |
| 21 00 1 | | | 0 | | 1.00 | 2.00 | 3.00 | |
| provid | e cost report prepared only using the er's records? If yes, see ctions. | | | | N | | N | 21.00 |
| COMPLE | TED BY COST REIMBURSED AND TEFRA HOSPIT | ALS ONLY (FXC | CEPT CHT | I DRENS HO | SPTTALS) | | 1.00 | |
| Capita | l Related Cost | | | | J. 21/12J | | | - |
| 23.00 Have c | ssets been relifed for Medicare purpose hanges occurred in the Medicare depreci ing period? If yes, see instructions. | es? If yes, se iation expense | ee insti e due to | uctions appraisa | ls made dui | ring the cost | N N | 22.00 23.00 |
| 24.00 Were n If yes | ew leases and/or amendments to existing , see instructions | | | | | | N | 24.00 |
| instru | here been new capitalized leases entere ctions. | | | | | | N | 25.00 |
| instru | ssets subject to Sec.2314 of DEFRA acquections. | | | | | | N N | 26.00 |
| copy. | terest Expense | | | | | | | 27.00 |
| 8.00 Were n | ew loans, mortgage agreements or letter ? If yes, see instructions. | | | | | _ | N | 28.00 |
| 9.00 Did th treate | e provider have a funded depreciation a d as a funded depreciation account? If | ves. see inst | truction | S | | | N | 29.00 |
| ınstru | isting debt been replaced prior to its ctions. | | | | | | N | 30.00 |
| instru | bt been recalled before scheduled matur ctions. sed Services | — without i | issuance | of new d | ebt? If yes | s, see | N | 31.00 |
| 2.00 Have c | hanges or new agreements occurred in pa ements with suppliers of services? If v | es. see instr | ructions | _ | | | N | 32.00 |
| 33.00 If line no, se | e 32 is yes, were the requirements of se instructions. er-Based Physicians | Sec. 2135.2 ap | pplied p | ertaining | to competi | tive bidding? I | N | 33.00 |
| 34.00 Are se If yes | rvices furnished at the provider facili , see instructions. | | | | | | Y | 34.00 |
| 55.00 If line physic | e 34 is yes, were there new agreements ians during the cost reporting period? | or amended ex If yes, see i | xisting instruct | agreement ions. | s with the | provider-based | N | 35.00 |
| Home Of | fice Costs | | | -11 TO 1 T | | 1.00 | Date 2.00 | |
| 6.00 Were he | ome office costs claimed on the cost re | port? | | | | N | T | 30 00 |
| 7.00 If line If yes | e 36 is yes, has a home office cost sta , see instructions. | tement been p | | | | , N | | 36.00 37.00 |
| the pro | e 36 is yes , was the fiscal year end o ovider? If yes, enter in column 2 the f | iscal vear en | nd of th | e home of | fice | | | 38.00 |
| see ins | e 36 is yes, did the provider render se structions. e 36 is yes, did the provider render se | | | | | | | 39.00 |
| instruc | ctions. | ivices to the | nome o | rrice? I | r yes, see | N | | 40.00 |
| | | | | 1.00 |) | 7 | .00 | |
| 1.00 Enter t | port Preparer Contact Information he first name, last name and the title of the cost report preparer in columns 1 | /position , 2, and 3, | JAKE | | | CARNAZZO | | 41.00 |
| 2.00 Enter t | the employer/company name of the cost rer. | | ALLIAN | MANAGEME | ENT SERVICE | s | | 42.00 |
| 3.00 Enter t | he telephone number and email address preparer in columns 1 and 2, respective | of the cost ely. | 502992 | 3476 | | JCARNAZZO@ALLI COM | ANTMANAGEMENT. | 43.00 |

| | Financial Systems | WARASH COUN | ITY HOSPITAL | | u of Form CMS-2552-1 |
|-------|--|--------------------------|-----------------------|---|----------------------|
| 105PI | TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE | STIONNAIRE | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | |
| | | Part B | | | |
| | | Date 4.00 | · | | |
| | PS&R Data | 4.00 | | | |
| L6.00 | | 01/18/2013 | | | 16.0 |
| | instructions) | , | | | |
| 17.00 | Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns | • | | | 17.00 |
| .8.00 | made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file | | | | 18.00 |
| 9.00 | this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions. | | | | 19.0 |
| 0.00 | If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments: | | | | 20.00 |
| 1.00 | was the cost report prepared only using the provider's records? If yes, see instructions. | | | | 21.00 |
| | | | 3,00 | | |
| | Cost Report Preparer Contact Information | | 1 3.00 | | |
| 1.00 | Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively. | /position , 2, and 3, | REIMBURSEMENT MANAGER | | 41.00 |
| 2.00 | Enter the employer/company name of the cost repreparer. | eport | | | 42.00 |
| 3.00 | Enter the telephone number and email address report preparer in columns 1 and 2, respectiv | of the cost | | | 43.00 |

| TARY CONTACT INFORMATION | Provider CCN: 151310 | Period: Worksheet S- From 01/01/2012 Part V To 12/31/2012 Date/Time Pr 5/29/2013 8: | epared: |
|--|---|---|--|
| | | 1.00 | _ |
| Cost Report Preparer Contact Information | | | |
| First Name | | JAKE | 1.0 |
| Last Name | | CARNAZZO | 2.0 |
| Title | | DIRECTOR OF REIMBURSEMENT | 3.0 |
| Employer | | ALLIANT MANAGEMENT | 4.0 |
| · ···································· | | (502)992-3476 | 5.0 |
| E-mail Address | | JCARNAZZO@ALLIANTMANAGEMENT | . 6.0 |
| Department | | | 7.0 |
| Mailing Address 1 | | 2650 EASTPOINT PARKWAY | 8.0 |
| Mailing Address 2 | | SUITE 310 | 9.0 |
| City | | LOUISVILLE | 10.0 |
| State | | K | 1 |
| | | 40222 | 12.0 |
| Officer or Administrator of Provider Contact Information | | | 1 |
| in the state of th | | JANE | □ 13.00 |
| | | BISSEL | 14.0 |
| | | CF0 | 15.0 |
| ' '/ ' | | WABASH COUNTY HOSPITAL | 16.0 |
| 1 | | (260) 569-2247 | 17.0 |
| | | JANE.BISSEL@WCHOSPITAL.COM | 18.0 |
| | | | 19.0 |
| | | | 20.0 |
| | | 710 NORTH EAST STREET | 21.0 |
| | | WABASH | 22.0 |
| | | | N 23.00 |
| LIP | | 46992 | 24.00 |
| | Cost Report Preparer Contact Information First Name Last Name Title Employer Phone Number E-mail Address Department Mailing Address 1 Mailing Address 2 City | Cost Report Preparer Contact Information First Name Last Name Title Employer Phone Number E-mail Address Department Mailing Address 2 City State Zip Officer or Administrator of Provider Contact Information First Name Last Name Title Employer First Name Last Name Title Employer Phone Number E-mail Address 2 City State Zip Officer or Administrator of Provider Contact Information First Name Last Name Title Employer Phone Number E-mail Address Department Mailing Address 1 Mailing Address 2 City State | Provider CCN: 151310 Period: From 01/01/2012 Part V pate/Time Provider Section 12/31/2012 Provider Section 13/2012 Pr |

| IFS S | upplemental Information P | rovider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | 5/29/2013 8:0 | pared |
|-------|--|--|--|---------------|--------------------|
| | | | Title V | Title XIX | |
| | | | 1.00 | 2.00 | |
| .00 | TITLES V AND/OR XIX FOLLOWING MEDICARE | | | | |
| 00 | Do Title V or XIX follow Medicare (Title XVIII) for the Interns a stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in co and Y/N in column 2 for Title XIX. | nd Residence post Tumn 1 for Title V | Y | Y | 1.0 |
| .00 | Do Title V or XIX follow Medicare (Title XVIII) for the reporting Part I (e.g. net of Physician's component)? Enter Y/N in column 1 in column 2 for Title XIX. | of charges on W/S C for Title V and Y/N | Υ Υ | Y | 2.0 |
| .00 | Do Title V or XIX follow Medicare (Title XVIII) for the calculating Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title 2 for Title XIX. | on of Observation Be e V and Y/N in colum | d n | Y | 3.0 |
| | Office 19 10 data and | programmer is a substitute of the first of the substitute of the s | Inpatient | Outpatient | The setting to the |
| | | | 1.00 | 2.00 | 1 |
| | CRITICAL ACCESS HOSPITALS | | The second secon | | |
| .00 | Does Title V follow Medicare (Title XVIII) for Critical Access Ho reimbursed 101% of cost? Enter Y or N in column 1 for inpatient a for outpatient. | spitals (CAH) being nd Y or N in column | N 2 | N | 4.0 |
| .00 | Does Title XIX follow Medicare (Title XVIII) for Critical Access reimbursed 101% of cost? Enter Y or N in column 1 for inpatient a for outpatient. | Hospitals (CAH) bein nd Y or N in column | g N 2 | N | 5.0 |
| | | | Title V | Title XIX | |
| | | | 1.00 | 2.00 | |
| • | RCE DISALLOWANCE | | | | 1 |
| .00 | Do Title V or XIX follow Medicare and add back the RCE Disallowan column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for PASS THROUGH COST | ce on W/S C, Part I or Title XIX. | Y | Υ | 6.0 |
| .00 | | and a nounce | | | l |
| .00 | Do Title V or XIX follow Medicare when cost reimbursed (payment sworksheets D, parts I through IV? Enter Y/N in column 1 for Title 2 for Title XIX. | ystem is 'O') for V and Y/N in column | Y | Y | 7.0 |

| | TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC | | Trovider | | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-3 Part I Date/Time Pre 5/29/2013 8:0 | epared: |
|--|---|---|------------------------------------|--|---|---|--|
| | Component | Worksheet A Line Number 1.00 | No. of Beds | Bed Days Available | | I/P Days / O/P Visits / Trips Title V | ' |
| 1.00 | Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and | | 2.00 | 3.00 9,15 | | 5.00 | 1.00 |
| 2.00 | Hospice days) | | | İ | | | 2.00 |
| 3.00 | HMO IPF Subprovider | | • | 1 | | | 3.00 |
| 4.00 | HMO IRF Subprovider | | | 1 | | | 4.0 |
| 5.00 | Hospital Adults & Peds. Swing Bed SNF | | | 1 | | 0 | |
| 6.00 7.00 | Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation | | 25 | 0.15 | 64 360 00 | 0 | |
| | beds) (see instructions) | | 25 | 9,15 | 0 54,360.00 | 0 | 7.0 |
| 8.00 | INTENSIVE CARE UNIT | | | ı | | | 8.0 |
| 9.00 | CORONARY CARE UNIT | | | | | | 9.0 |
| 10.00 | | | | | | | 10.0 |
| 12.00 | | | | | | | 11.0 |
| 13.00 | NURSERY | 43.00 | | | | 0 | 1 |
| 14.00 | | | 25 | 9,15 | 0 54,360.00 | | |
| 15.00 | | | | | | 0 | 15.0 |
| 16.00 17.00 | 1 | | | | | | 16.0 |
| 18.00 | | | | | | | 17.0 |
| 19.00 | SKILLED NURSING FACILITY | 44.00 | 25 | 9,15 | o | 0 | $ 18.0 \\ 19.0 $ |
| 20.00 | 1 | | | -, | | Ĭ | 20.0 |
| 21.00 | | | | | | | 21.0 |
| 22.00 23.00 | | 101.00 | | | | 0 | |
| 24.00 | | 116.00 | o | | 0 | | 23.0 |
| 25.00 | | 110.00 | ٩ | , | 1 | | 24.0 |
| 26.00 | 1 | | | | | | 26.0 |
| 26.25 | | | | | | | 26.2 |
| 27.00 28.00 | 1 | | 50 | | | | 27.0 |
| 29.00 | 9- | | | | | 0 | 1 |
| 30.00 | , · · · · · · · · · · · · · · · · · · · | | | | | | 29.0 |
| 31.00 | Employee discount days - IRF | | | | | | 31.0 |
| 32.00 | (| | | | | | 32.0 |
| 33.00 | LTCH non-covered days | T/D Davis | (0/0)/4-4 | / +===== | | <u></u> | 33.0 |
| | | 1/P Days | / O/P Visits | / Irips | Full Time E | Equivalents | |
| | Component | Title XVIII | Title XIX | Total All Patients | Total Interns & Residents | Employees On Payroll | |
| 1 00 | | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| 1.00 | Hospital Adults & Peds. (columns 5, 6, 7 and | 1,202 | 64 | 2,26 | 5 | | 1.00 |
| | IX BYCIIIDB SWIND ROD Obcomustion had ! | -, | ١,٠ | ۷,20 | - | l i | 1.00 |
| | 8 exclude Swing Bed, Observation Bed and Hospice days) | _, | | 2,20 | | | 1.0 |
| | Hospice days) HMO | 445 | 0 | 2,20 | | | |
| 3.00 | Hospice days) HMO HMO IPF Subprovider | 445 0 | 0 | 2,20 | | | 2.0 |
| 3.00 4.00 | Hospice days) HMO HMO IPF Subprovider HMO IRF Subprovider | 445 0 0 | 0 0 | | | | 2.0 |
| 3.00 4.00 5.00 | Hospice days) HMO HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF | 445 0 | 0 0 0 0 | 178 | 8 | | 2.0 3.0 4.0 5.0 |
| 3.00 4.00 5.00 5.00 | Hospice days) HMO HMO IPF Subprovider HMO IRF Subprovider HOSpital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF | 445 0 0 178 | 0 0 0 0 0 67 | 178 67 | 8 | | 2.0 3.0 4.0 5.0 6.0 |
| 3.00 4.00 5.00 5.00 7.00 | Hospice days) HMO HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) | 445 0 0 | 0 0 0 0 | 178 | 8 | | 2.0 3.0 4.0 5.0 6.0 |
| 3.00 4.00 5.00 6.00 7.00 | Hospice days) HMO HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT | 445 0 0 178 | 0 0 0 0 0 67 | 178 67 | 8 | | 2.0 3.0 4.0 5.0 6.0 7.0 |
| 3.00 4.00 5.00 5.00 7.00 3.00 | Hospice days) HMO HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT | 445 0 0 178 | 0 0 0 0 0 67 | 178 67 | 8 | | 2.00 3.00 4.00 5.00 6.00 7.00 |
| 3.00 4.00 5.00 5.00 7.00 3.00 9.00 L0.00 | Hospice days) HMO HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT | 445 0 0 178 | 0 0 0 0 0 67 | 178 67 | 8 | | 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 |
| 3.00 4.00 5.00 6.00 7.00 3.00 9.00 10.00 11.00 12.00 | Hospice days) HMO HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT | 445 0 0 178 | 0 0 0 0 0 67 | 178 67 | 8 | | 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 |
| 3.00 4.00 5.00 5.00 7.00 3.00 0.00 11.00 12.00 | Hospice days) HMO HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY | 445 0 0 178 | 0 0 0 0 0 67 | 178 67 | 8 | | 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 |
| 3.00 4.00 5.00 6.00 7.00 3.00 9.00 10.00 11.00 12.00 13.00 14.00 | Hospice days) HMO HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) | 445 0 0 178 | 0 0 0 0 67 131 | 178 67 | 8 7 0 | 243.99 | 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 |
| 3.00 4.00 5.00 5.00 7.00 3.00 0.00 1.00 1.00 1.00 1.00 1.00 1 | Hospice days) HMO HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits | 445 0 0 178 1,380 | 0 0 0 0 67 131 | 178 67 2,510 | 8 7 0 | 243.99 | 2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0 11.0 11.0 12.0 13.0 14.0 15.0 |
| 3.00 4.00 5.00 6.00 7.00 3.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 | Hospice days) HMO HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF | 445 0 0 178 1,380 | 0 0 0 0 67 131 | 178 67 2,510 | 8 7 0 | 243.99 | 2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0 10.0 11.0 12.0 13.0 14.0 15.0 16.0 |
| 3.00 4.00 5.00 5.00 7.00 3.00 0.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 | Hospice days) HMO HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER | 445 0 0 178 1,380 | 0 0 0 0 67 131 | 178 67 2,510 | 8 7 0 | 243.99 | 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 14.00 15.00 16.00 17.00 |
| 3.00 4.00 5.00 5.00 6.00 7.00 3.00 6.00 | Hospice days) HMO HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY | 445 0 0 178 1,380 | 0 0 0 0 67 131 | 178 67 2,510 (2,510 | 8 7 0 0 0 0 0 | | 2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0 11.0 12.0 13.0 14.0 15.0 16.0 17.0 18.0 |
| 3.00 4.00 5.00 5.00 7.00 3.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 19.00 19.00 19.00 | Hospice days) HMO HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY | 445 0 0 178 1,380 | 0 0 0 67 131 0 | 178 67 2,510 | 8 7 0 0 0 0 0 0 | | 2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0 10.0 11.0 12.0 13.0 14.0 15.0 16.0 17.0 18.0 19.0 |
| 3.00 4.00 5.00 5.00 5.00 7.00 3.00 0.00 12.00 12.00 14.00 15.00 16.00 17.00 8.00 9.00 11.00 12.00 12.00 13.00 14.00 15.00 16.00 16.00 17.00 18.00 19.00 | Hospice days) HMO HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE | 445 0 0 178 1,380 1,380 0 | 0 0 0 0 67 131 0 | 178 67 2,510 (2,510 (4,205 | 0.00 0.00 0.00 | | 2.00 3.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 12.00 14.00 15.00 17.00 18.00 19.00 20.00 |
| 3.00 4.00 5.00 6.00 7.00 3.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19 | Hospice days) HMO HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY | 445 0 0 178 1,380 | 0 0 0 67 131 0 | 178 67 2,510 (2,510 | 0.00 0.00 0.00 | | 2.00 3.00 4.00 5.00 6.00 7.00 8.00 10.00 11.00 12.00 14.00 15.00 17.00 18.00 19.00 20.00 21.00 22.00 |
| 3.00 4.00 5.00 5.00 6.00 7.00 3.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19 | Hospice days) HMO HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT SURGICAL INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE | 445 0 0 178 1,380 1,380 0 | 0 0 0 0 67 131 0 | 178 67 2,510 (2,510 4,205 | 0.00 0.00 0.00 0.00 | 14.55 19.12 | 2.00 3.00 4.00 5.00 6.00 7.00 8.00 10.00 11.00 12.00 13.00 15.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 |
| 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 | Hospice days) HMO HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE CMHC - CMHC | 445 0 0 178 1,380 1,380 0 | 0 0 0 0 67 131 0 | 178 67 2,510 (2,510 (4,205 | 0.00 0.00 0.00 0.00 | 14.55 19.12 | 2.00 3.00 4.00 5.00 6.00 7.00 8.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 20.00 21.00 22.00 23.00 24.00 |
| 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 26.00 27.00 | Hospice days) HMO HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE CMHC - CMHC | 445 0 0 178 1,380 1,380 0 | 0 0 0 0 67 131 0 | 178 67 2,510 (2,510 4,205 | 0.00 0.00 0.00 0.00 | 14.55 19.12 | 2.00 3.00 4.00 5.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 19.00 20.00 21.00 |

 Health Financial Systems
 WABASH

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151310

Period: Worksheet S-3
From 01/01/2012 Part I
To 12/31/2012 Date/Time Prepared: 5/29/2013 8:08 am

| | | T/P Davs | / O/P Visits | / Trins | Full Time E | 5/29/2013 8:0 | 8 am |
|-------|--|-------------|--------------|--|------------------------------|---|-------|
| | | 1/1 Days | / 0/1 113163 | , 11 ips | ruit time t | equivarents | Ì |
| | Component | Title XVIII | Title XIX | Total All Patients | Total Interns & Residents | Employees On Payroll | |
| | The second secon | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| 27.00 | Total (sum of lines 14-26) | | | | 0.00 | 286.20 | 27.00 |
| 28.00 | Observation Bed Days | | 0 | 292 | | | 28.00 |
| 29.00 | Ambulance Trips | 0 | | | | | 29.00 |
| 30.00 | Employee discount days (see instruction) | | | 0 | | | 30.00 |
| 31.00 | Employee discount days - IRF | | | 0 | l I | | 31.00 |
| | Labor & delivery days (see instructions) | | 0 | 0 | | | 32.0 |
| 33.00 | LTCH non-covered days | 0 | | THE AND A CO. L. C. A. M. AND AND ADDRESS ASSESSMENT AS | | | 33.0 |
| | | Full Time | | Disch | arges | | |
| | Camman and | Equivalents | | | | riumen kontrekki i Pakin di di sindaki je jela kasin konsekto nimakansansansansansa | |
| | Component | Nonpaid | Title V | Title XVIII | Title XIX | Total All | |
| | | Workers | 12.00 | | | Patients | |
| 1.00 | Hospital Adults & Peds. (columns 5, 6, 7 and | 11.00 | 12.00 | 13.00 | 14.00 | 15.00 | ļ |
| 1.00 | 8 exclude Swing Bed, Observation Bed and | | 0 | 330 | 16 | 672 | 1.00 |
| | Hospice days) | | | | | | |
| 2.00 | HMO | | | 131 | | | |
| 3.00 | HMO IPF Subprovider | | | 131 | | | 2.0 |
| 4.00 | HMO IRF Subprovider | | | | | | 3.00 |
| 5.00 | Hospital Adults & Peds. Swing Bed SNF | | | | | | 4.0 |
| 6.00 | Hospital Adults & Peds. Swing Bed NF | | | | | | 5.0 |
| 7.00 | Total Adults and Peds. (exclude observation | | | | | | 6.0 |
| | beds) (see instructions) | | | | | | 7.0 |
| 8.00 | INTENSIVE CARE UNIT | | | | | | 0.0 |
| 9.00 | CORONARY CARE UNIT | | | | | | 8.00 |
| 10.00 | BURN INTENSIVE CARE UNIT | | | | | | 9.0 |
| 11.00 | SURGICAL INTENSIVE CARE UNIT | | | |] | | 11.0 |
| 12.00 | OTHER SPECIAL CARE (SPECIFY) | | | | İ | | 12.00 |
| 13.00 | NURSERY | | | | | | 13.0 |
| 14.00 | Total (see instructions) | 0.00 | 0 | 330 | 16 | 672 | |
| 15.00 | CAH visits | | • | 330 | | 0/2 | 15.0 |
| | SUBPROVIDER ~ IPF | | | | 1 | | 16.0 |
| | SUBPROVIDER ~ IRF | | | | | | 17.0 |
| | SUBPROVIDER | | | | | | 18.00 |
| 19.00 | SKILLED NURSING FACILITY | 0.00 | | | | | 19.00 |
| | NURSING FACILITY | | | | | | 20.00 |
| | OTHER LONG TERM CARE | | | | | | 21.00 |
| 22.00 | HOME HEALTH AGENCY | 0.00 | | | | | 22.00 |
| 23.00 | AMBULATORY SURGICAL CENTER (D.P.) | | | | | | 23.00 |
| | HOSPICE | 0.00 | | | | | 24.00 |
| | CMHC - CMHC | | | | | | 25.00 |
| 26.00 | RURAL HEALTH CLINIC | | | | | | 26.00 |
| 26.25 | FEDERALLY QUALIFIED HEALTH CENTER | | | | | | 26.25 |
| | Total (sum of lines 14-26) | 0.00 | | | | | 27.00 |
| | Observation Bed Days | | | | ļ | ł | 28.00 |
| 29.00 | Ambulance Trips | | | | | | 29.00 |
| 30.00 | Employee discount days (see instruction) | | | | | | 30.00 |
| 31.00 | Employee discount days - IRF | | | | | | 31.00 |
| 32.00 | Labor & delivery days (see instructions) | | | | | | 32.00 |
| 22 00 | LTCH non-covered days | | | | | 1 | |

| 1 | | Amount | |
|---------|--|--|-------|
| 1 | | Reported | |
| 1 | ADT TV MOD DELIVER | 1.00 | |
| | ART IV - WAGE RELATED COSTS art A - Core List | · | |
| | ETIREMENT COST | | 1 |
| | 101K Employer Contributions | The state of the s | |
| | Tax Sheltered Annuity (TSA) Employer Contribution | 0 | |
| 3.00 N | AN SHETCHED ANNUTLY (TSA) Employer Contribution Honqualified Defined Benefit Plan Cost (see instructions) | 0 | , -, |
| 4.00 0 | Nonlifered Perined Benefit Plan Cost (see Instructions) | 0 | 3.00 |
| 4.00 | nualified Defined Benefit Plan Cost (see instructions) | 724,997 | 4.00 |
| 5.00 4 | LAN ADMINISTRATIVE COSTS (Paid to External Organization) 01K/TSA Plan Administration fees | | |
| | | 0 | |
| | egal/Accounting/Management Fees-Pension Plan | 0 | 0.00 |
| | mployee Managed Care Program Administration Fees | 0 | 7.00 |
| - | EALTH AND INSURANCE COST | | |
| | lealth Insurance (Purchased or Self Funded) | 3,444,089 | |
| | rescription Drug Plan | 0 | 1 |
| 10.00 b | pental, Hearing and Vision Plan | 0 | |
| 12.00 A | ife Insurance (If employee is owner or beneficiary) | 29,020 | 1 |
| 13.00 A | ccident Insurance (If employee is owner or beneficiary) | 0 | |
| 13.00 | risability Insurance (If employee is owner or beneficiary) | 40,493 | 13.00 |
| 14.00 L | ong-Term Care Insurance (If employee is owner or beneficiary) | 0 | 14.00 |
| 16.00 | Workers' Compensation Insurance | 139,544 | 15.00 |
| 16.00 R | etirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. | 0 | 16.00 |
| | on cumulative portion) AXES | | ļ |
| 17.00 F | ICA-Employers Portion Only | 981,435 | 17.00 |
| | edicare Taxes - Employers Portion Only | 961,433 | |
| 19.00 U | nemployment Insurance | 60,190 | |
| 20.00 s | tate or Federal Unemployment Taxes | 00,190 | 1 |
| | THER | | 20.00 |
| 21.00 E | xecutive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (se | ie 0 | 21.00 |
| 11 | nstructions)) | | 21.00 |
| 22.00 D | ay Care Cost and Allowances | 0 | 22.00 |
| | uition Reimbursement | 56,792 | |
| 24.00 T | otal Wage Related cost (Sum of lines 1 -23) | 5,476,560 | |
| Pa | art B - Other than Core Related Cost | 1 2,470,300 | 24.00 |
| 25.00 o | THER WAGE RELATED COSTS (SPECIFY) | | 25.00 |

| HUME | HEALTH AGENCY STATISTICAL DATA | | | | Period: From 01/01/2012 To 12/31/2012 | | pared: |
|---------------|---|---------------------|-------------------------------|---------------|---|----------------------|--------|
| | | | | | Home Health Agency I | 5/29/2013 8:0 PPS | 8 am |
| | | | | | 1. | 00 | |
| 0.00 | County | | | | WABASH | | 0.00 |
| | | Title V | Title XVIII | Title XIX | Other | Total | |
| | HOME HEALTH AGENCY STATISTICAL DATA | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| L.00 | Home Health Aide Hours | T 0 | | ol | 0 0 | 0 | 1.00 |
| 2.00 | Unduplicated Census Count (see instructions) | 0.00 | 140.0 | 0.0 | 0.00 | 140.00 | |
| | | | | Number of Em | oloyees (Full Ti | me Equivalent) | |
| | | Enter the numb | er of hours in 1 work week | Staff | Contract | Total | |
| | | y day may ma | , work week | | | | |
| | HOME HEALTH AGENCY - NUMBER OF EMPLOYEES | | 0 | 1.00 | 2.00 | 3.00 | |
| .00 | Administrator and Assistant Administrator(s) | | 0.00 | 0.0 | 0.00 | 0.00 | 3.0 |
| 1.00 | Director(s) and Assistant Director(s) Other Administrative Personnel | | | 0.0 | 1 | 0.00 | 1 |
| .00 | Direct Nursing Service | | | 0.0 | | 0.00 0.00 | 5.0 |
| '.00 | Nursing Supervisor | | | 0.0 | | 0.00 | |
| 3.00 | Physical Therapy Service | | | 0.0 | | 0.00 | |
| 0.00 L0.00 | Physical Therapy Supervisor Occupational Therapy Service | | | 0.0 | | 0.00 | |
| | | | | 0.0 | . 1 | 0.00 |] - |
| 12.00 | Speech Pathology Service | | | 0.0 | 1 | 0.00 0.00 | |
| L3.00 | Speech Pathology Supervisor | | | 0.0 | 1 | 0.00 | |
| | Medical Social Service | | | 0.0 | | 0.00 | |
| | Medical Social Service Supervisor Home Health Aide | | | 0.0 | | 0.00 | |
| 17.00 | Home Health Aide Supervisor | | | 0.0 | | 0.00 | |
| .8.00 | Other (specify) | | | 0.0 | 1 1 | 0.00 | |
| 0 00 | HOME HEALTH AGENCY CBSA CODES | | | | | | 10.0 |
| 9.00 | Enter in column 1 the number of CBSAs where you provided services during the cost reporting period. | | | | 1 | | 19.0 |
| 0.00 | | | | 15999 | | | 20.00 |
| | | Full Ep | | | | | |
| | | Without Outliers | With Outliers | LUPA Episodes | PEP Only Episodes | Total (cols. 1-4) | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 1.00 | PPS ACTIVITY DATA | | | | | | |
| | Skilled Nursing Visits Skilled Nursing Visit Charges | 884 429,800 | | | | | 21.00 |
| 3.00 | Physical Therapy Visits | 1,086 | | | 0 15,120 8 22 | 468,300 1,116 | |
| 4.00 | Physical Therapy Visit Charges | 214,455 | ď | 1 | | 222,865 | |
| 5.00 | Occupational Therapy Visits | 207 | C | | 0 11 | 218 | |
| 6.00 7.00 | Occupational Therapy Visit Charges Speech Pathology Visits | 35,235 | C | Į. | 2,030 | 37,265 | |
| 8.00 | Speech Pathology Visit Charges | 22 9,715 | C | i | 0 0 | 22 | 27.00 |
| 9.00 | Medical Social Service Visits | 7 | C | • | 0 0 | 9,715 7 | 28.00 |
| 0.00 | Medical Social Service Visit Charges | 1,190 | C | | o o | 1,190 | |
| 1.00 2.00 | Home Health Aide Visits Home Health Aide Visit Charges | 609 | 0 | | 1 2 | 612 | 31.00 |
| 3.00 | Total visits (sum of lines 21, 23, 25, 27, | 49,329 2,815 | 0 | · · | 1 | 49,572 | 32.00 |
| | 29, and 31) | 2,013 | U |) 5 | 63 | 2,930 | 33.00 |
| 4.00 5.00 | Other Charges Total Charges (sum of lines 22, 24, 26, 28, | 739 724 | 0 | | 0 0 | 0 | 34.00 |
| | 30, 32, and 34) Total Number of Episodes (standard/non | 739,724 | 0 | ,5. | | 788,907 | 35.00 |
| 7.00 | outlier) | 157 | | 1 | 8 4 | 179 | 36.00 |
| | Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges | | 0 | | 0 | 0 | 37.00 |

| SPE | Financial Systems WABASH COUNTY CTIVE PAYMENT FOR SNF STATISTICAL DATA | | | Period: From 01/01/2012 | Worksheet S-7 | |
|----------|--|-----------------------------|-----------------------------|----------------------------|--------------------------------|--------------|
| - | | | | го 12/31/2012 | Date/Time Pre 5/29/2013 8:0 | pare 8 am |
| | | | | 1.00 | 2.00 | |
| 00 | If this facility contains a hospital-based SNF, were all pat or was there no Medicare utilization? Enter "Y" for yes in c | ients under moder i | nanaged care do not | N | | 1. |
| 00 | complete the rest of this worksheet. Does this hospital have an agreement under either section 18 swing beds? Enter "Y" for yes or "N" for no in column 1. If | 83 or section yes, enter | n 1913 for the agreement | Y | 12/17/2001 | 2. |
| | date (mm/dd/yyyy) in column 2. | Group | SNF Days | 1 - | Total (sum of col. 2 + 3) | _ |
| | | 1.00 | 2.00 | Days 3.00 | 4.00 | |
| 00 | | RUX | | 0 | 0 | |
|)0)0 | | RUL | | | 0 | 4 |
| 00 | | RVX RVL |) | | 0 | 5 |
| 00 | | RHX | 1 | | 0 | 7 |
| 00 | | RHL | | o o | 0 | 8 |
| 00 | | RMX | | 0 | ő | 9 |
| 00 | | RML | | 0 | 0 | 10 |
| 00 | | RLX | | 0 | 0 | 11 |
| 00 | | RUC | 1 | 0 | 0 | |
| 00 | | RUB | (| 0 | 0 | 13 |
| 00 | | RUA | | 0 | 0 | 14 |
| 00 | | RVC | | 0 | 0 | |
| 00 | | RVB | | 0 | 0 | 16 |
| 00 | | RVA | | 0 | 0 | 17 |
| 00 | | RHC | 1. | | 14 | |
| 00 00 | · | RHB | 2 | | 25 | 1 |
| 00 | | RHA | 8: | | 83 | |
| 00 | | RMC | 130 17 | | | |
| 00 | | RMB RMA | 27 | | 173 | 1 |
| 00 | | RMA RLB | 4 | | | |
| 00 | | RLA | | | 0 | 1 |
| 00 | | ES3 | 1 | 0 0 | 0 | 26 |
| 00 | | ES2 | 1 | ő | ő | |
| 00 | | ES1 | | o o | ő | 28 |
| 00 | | HE2 | | o o | ŏ | 1 |
| 00 | | HE1 | | 1 0 | 1 | 30 |
| 00 | | HD2 | | 0 | 0 | 31 |
| 00 | | HD1 | (| 0 | 0 | 32 |
| 00 | | HC2 | | 0 | 0 | 33 |
| 00 | | HC1 | 2. | 4 0 | 24 | 34 |
| 00 | | нв2 | | 0 | 0 | 35 |
| 00 | | нв1 | E . | 0 | 0 | 36 |
| 00 00 | | LE2 | | 0 | 0 | 37 |
| 00 | | LE1 | | 0 | 0 | 38 |
| 00 | | LD2 | | 0 | 0 | 39 |
| 00 | | LD1 LC2 | | 0 0 | 0 | 40 |
| 00 | | LC1 | 1 | | 0 | 41 |
| 00 | | LB2 | 1 | | 15 0 | 42 |
| 00 | | LB1 | | o o | 0 | 43 |
| 00 | | CE2 | | o o | 0 | 45 |
| 00 | | CE1 | | o o | ő | 46 |
| 00 | | CD2 | | o o | Ö | 47 |
| 00 | | CD1 | 10 | | 10 | 48 |
| 00 | | CC2 | | 0 | 0 | 49 |
| 00 | | CC1 | | 4 O | 4 | 50 |
| 00 | | CB2 | | 0 | 0 | 51 |
| 00 | | CB1 | | 0 5 0 | 5 | 52 |
| 00 | | CA2 | | 0 | . 0 | 53 |
|)O | | CA1 | 60 | 0 | 60 | 54 |
| 00 | | SE3 | | 0 | 0 | 55 |
| 00 | | SE2 | | 0 | 0 | 56 |
| 00 | | SE1 | | 0 | 0 | 57 |
| 00 | | SSC | | 0 | 0 | 58 |
| 00 | | SSB | | 0 | 0 | 59 |
| 00 | | SSA IB2 | | | 0 | 60 |
| 00 | | IB2 IB1 | | | 0 | 61 |
| 00 | | IA2 | | 0 0 | 0 | 62 |
| 00 | | IA2 | , | | 0 | 63 |
| 00 | | BB2 | , | 0 0 | 0 | 64 |
| 00 | | BB1 | | | 0 0 | 65 66 |
| | | | , | . 0 | Ui | סט |
| 00 00 | | BA2 | (| 0 | 0 | 67 |

| PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider | CCN: 151310 | Period: From 01/01/2012 | worksheet S- | |
|--|--|--|---|--|-------------------------|
| | | | To 12/31/2012 | Date/Time Pr 5/29/2013 8: | epared 08 am |
| | Group | SNF Days | Swing Bed SNF Days | Total (sum of col. 2 + 3) | |
| 69.00 | 1.00 | 2.00 | 3.00 | 4.00 | - |
| 70.00 | PE2 | | 0 0 | | 69.0 |
| 71.00 | PE1 | | 0 0 | | 70.0 |
| 72.00 | PD2 | | 0 0 | | 71.0 |
| 73.00 | PD1 | | 0 | | 72.0 |
| 74.00 | PC2 | | 0 0 | . (| 73.0 |
| 75.00 | PC1 | | 7 0 | | 7 74.0 |
| 76.00 | PB2 | | 0 | | 75.0 |
| 77,00 | PB1 | | 0 | | 76.0 |
| 8.00 | PA2 | | 0 | | 77.0 |
| 99.00 | PA1 | | 0 | Ò | 1 |
| 00.00 TOTAL | AAA | | 7 0 | , | 199.0 |
| OU. OU TOTAL | | 83 | 5 0 | | 200.0 |
| | | | CBSA at | CBSA on/after | |
| | | | Beginning of | October 1 of | |
| | | | Cost Reporting | the Cost | İ |
| | | | Period | Reporting | İ |
| | | | | Period (if | |
| | | | | applicable) | |
| SNF SERVICES | | vernesses a production of the second | 1.00 | 2.00 | |
| 01.00 Enter in column 1 the SNF CBSA code or 5 character | | many - many - many - many | ery continues on an armony areas are | | 7 |
| in the same of the same case of a character | | ral facility | 115000 | | i |
| in effect at the beginning of the cost reporting print effect on or after October 1 of the cost report | ariad Entar in calumn | الباسية ماسي | 15999 | 15999 | 201.0 |
| in criect at the beginning of the cost reporting of | ariad Entar in calumn | الباسية ماسي | Percentage | Associated with Direct | 201.0 |
| in criect at the beginning of the cost reporting of | ariad Entar in calumn | 2, the code ple). | | Associated with Direct Patient Care and Related | 201.0 |
| in effect on or after October 1 of the cost report | eriod. Enter in column ing period (if applical | 2, the code ole). Expenses | Percentage | Associated with Direct Patient Care and Related Expenses? | 201.0 |
| in effect on or after October 1 of the cost report A notice published in the Federal Register Volume 6 | eriod. Enter in column ing period (if applical | 2, the code ole). Expenses | Percentage | Associated with Direct Patient Care and Related Expenses? | 201.(|
| A notice published in the Federal Register Volume 6 payments beginning 10/01/2003. Congress expected the expenses. For lines 202 through 207: Enter in column column 2 the percentage of total expenses for each line 7, column 3. In column 3. enter "y" for year or | eriod. Enter in column ing period (if applical 68, No. 149 August 4, 2 is increase to be used in 1 the amount of the category to total SNF | 2, the code ole). Expenses 1.00 003 provided for direct prevenue from N | Percentage 2.00 for an increase atient care and ach category. En | Associated with Direct Patient Care and Related Expenses? 3.00 in the RUG related ter in | 201.0 |
| A notice published in the Federal Register Volume 6 payments beginning 10/01/2003. Congress expected the expenses. For lines 202 through 207: Enter in column column 2 the percentage of total expenses for each line 7, column 3. In column 3, enter "Y" for yes or with direct patient care and related expenses for each | eriod. Enter in column ing period (if applical 68, No. 149 August 4, 2 is increase to be used in 1 the amount of the category to total SNF | 2, the code ole). Expenses 1.00 003 provided for direct prevenue from N | 2.00 for an increase attient care and ach category. En worksheet G-2, ps increases asso | Associated with Direct Patient Care and Related Expenses? 3.00 in the RUG related ter in | 201.0 |
| A notice published in the Federal Register Volume 6 payments beginning 10/01/2003. Congress expected the expenses. For lines 202 through 207: Enter in column column 2 the percentage of total expenses for each line 7, column 3. In column 3, enter "Y" for yes or with direct patient care and related expenses for e 12.00 Staffing | eriod. Enter in column ing period (if applical 68, No. 149 August 4, 2 is increase to be used in 1 the amount of the category to total SNF | 2, the code ole). Expenses 1.00 003 provided for direct presence for expense for expense from which is tructions) | 2.00 for an increase attient care and ach category. En worksheet G-2, P is increases asso | Associated with Direct Patient Care and Related Expenses? 3.00 in the RUG related ter in | |
| A notice published in the Federal Register Volume 6 payments beginning 10/01/2003. Congress expected th expenses. For lines 202 through 207: Enter in column column 2 the percentage of total expenses for each line 7, column 3. In column 3, enter "Y" for yes or with direct_patient care and related expenses for e 02.00 Staffing | eriod. Enter in column ing period (if applical 68, No. 149 August 4, 2 is increase to be used in 1 the amount of the category to total SNF | 2, the code ole). Expenses 1.00 003 provided for direct prespense for expense from which it is the condition of the condition of the condition of the code of t | 2.00 for an increase attient care and ach category. En worksheet G-2, P increases asso | Associated with Direct Patient Care and Related Expenses? 3.00 in the RUG related ter in art I, ciated | 202.0 |
| A notice published in the Federal Register Volume 6 payments beginning 10/01/2003. Congress expected th expenses. For lines 202 through 207: Enter in colum column 2 the percentage of total expenses for each line 7, column 3. In column 3, enter "Y" for yes or with direct_patient care and related expenses for e 02.00 Staffing 03.00 Recruitment 04.00 Retention of employees | eriod. Enter in column ing period (if applical 68, No. 149 August 4, 2 is increase to be used in 1 the amount of the category to total SNF | 2, the code ole). Expenses 1.00 003 provided for direct presence for expense for expense from which is tructions) | 2.00 for an increase attient care and ach category. En worksheet G-2, P increases asso | Associated with Direct Patient Care and Related Expenses? 3.00 in the RUG related ter in art I, ciated | 202.0 |
| A notice published in the Federal Register Volume 6 payments beginning 10/01/2003. Congress expected the expenses. For lines 202 through 207: Enter in column column 2 the percentage of total expenses for each line 7, column 3. In column 3, enter "Y" for yes or with direct_patient care and related expenses for e 32.00 Staffing Recruitment Page 104.00 Recruitment Page 105.00 Training | eriod. Enter in column ing period (if applical 68, No. 149 August 4, 2 is increase to be used in 1 the amount of the category to total SNF | 2, the code ole). Expenses 1.00 003 provided for direct prespense for expense from which it is the condition of the condition of the condition of the code of t | 2.00 for an increase attient care and ach category. En worksheet G-2, Ps increases asso 0.00 0.00 0.00 0.00 | Associated with Direct Patient Care and Related Expenses? 3.00 in the RUG related ter in art I, ciated | 202.0 203.0 204.0 |
| A notice published in the Federal Register Volume 6 payments beginning 10/01/2003. Congress expected the expenses. For lines 202 through 207: Enter in column column 2 the percentage of total expenses for each line 7, column 3. In column 3. enter "y" for year or | eriod. Enter in column ing period (if applical 68, No. 149 August 4, 2 is increase to be used in 1 the amount of the category to total SNF "N" for no if the speach category. (see ins | 2, the code ole). Expenses 1.00 003 provided for direct prespense for expense from a revenue | Percentage 2.00 for an increase attent category. En worksheet G-2, P increases asso 0.00 0.00 0.00 0.00 0.00 0.00 0.00 | Associated with Direct Patient Care and Related Expenses? 3.00 in the RUG related ter in art I, ciated | 202.0 |

| Health Financial Systems | WABASH COUNTY HOSPITAL | In Lieu of Form CMS-2552-10 |
|------------------------------|------------------------|-----------------------------------|
| HOSPITAL IDENTIFICATION DATA | | Period: Worksheet S-9 |
| | | From 01/01/2012 Parts I & II |
| | Component CCN: 151545 | To 12/31/2012 Date/Time Prepared: |

| | | | | Component | . CCN. 131343 | 10 12/31/2012 | 5/29/2013 8:08 | |
|------|---|----------------------|-----------|---|--|---------------|-------------------------------|--|
| | | | | | | Hospice I | | |
| | | Unduplicated Days | | | | | | |
| | | Title XVIII | Title XIX | Title XVIII Skilled Nursing Facility | Title XIX Nursing Facility | All Other | Total (sum of cols. 1, 2 & 5) | Alle Company (Sp. 1984) Albandon (Albane and A |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 6.00 | |
| | PART I - ENROLLMENT DAYS | | | A COLON | process are a construction of the construction | | | |
| 1.00 | Continuous Home Care | 0 | 0 | 0 | | 0 0 | 0 | 1.00 |
| 2.00 | Routine Home Care | 7,334 | 0 | 0 | | 0 | 7,334 | 2.00 |
| 3.00 | Inpatient Respite Care | 79 | 0 | 0 | | 0 0 | 79 | 3.00 |
| 4.00 | General Inpatient Care | 0 | 0 | 0 | | 0 0 | o | 4.00 |
| 5.00 | Total Hospice Days | 7,413 | 0 | 0 | | 0 0 | 7,413 | 5.00 |
| | Part II - CENSUS DATA | | | | | | | 5.00 |
| 6.00 | Number of Patients Receiving Hospice Care | 0 | 0 | 0' | | 0 | 0 | 6.00 |
| 7.00 | Total Number of Unduplicated Continuous Care Hours Billable to Medicare | 0.00 | | 0.00 | | | | 7.00 |
| 8.00 | Average Length of Stay (line 5/line 6) | 0.00 | 0.00 | 0.00 | 0.0 | 0.00 | 0.00 | 8.00 |
| 9.00 | Unduplicated Census Count | 0 | 0 | 0 | | 0 0 | o | 9.00 |

| | AL UNCOMPENSATED AND INDIGENT CARE DATA . PI | rovider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | | |
|--|--|---|---|--|--|
| | | | | 5/29/2013 8:0 | |
| namental de delibertura de ma gina | | | | 1.00 | |
| ١, | Incompensated and indigent care cost computation | | | | |
| 1.00 | Cost to charge ratio (Worksheet C, Part I line 202 column 3 divide | ed by line 202 colu | mn 8) | 0.371121 | 1.0 |
| | Medicaid (see instructions for each line) | | and the second section of the second | property and the second | |
| | Net revenue from Medicaid | | | 1,367,068 | 2. |
| .00 | Did you receive DSH or supplemental payments from Medicaid? | | | Y | 3. |
| .00 | If line 3 is "yes", does line 2 include all DSH or supplemental pa | ayments from Medica | id? | | 4. |
| .00 | If line 4 is "no", then enter DSH or supplemental payments from Me Medicaid charges | edicaid | | 242,502 | 5. |
| | | | | 5,789,998 | 6. |
| .00 | Medicaid cost (line 1 times line 6) | | | 2,148,790 | 7. |
| .00 | Difference between net revenue and costs for Medicaid program (lin < zero then enter zero) | ie / minus sum of l | ines 2 and 5; if | 539,220 | 8. |
| | state Children's Health Insurance Program (SCHIP) (see instruction | - 6 13> | | Translation to the second seco | |
| .00 | Net revenue from stand-alone SCHIP | s for each line) | | | |
| | Stand-alone SCHIP charges | | | 0 | 9. |
| | Stand-alone SCHIP cost (line 1 times line 10) | | | 0 | 10. |
| | Difference between net revenue and costs for stand-alone SCHIP (li | no 11 minus lina A | . if . zono +hon | 0 | 11. |
| | enter zero) | ine II minus iine 3 | , ii < zero then | 0 | 12. |
| | other state or local government indigent care program (see instruc | tions for each line | | | |
| 3.00 h | Net revenue from state or local indigent care program (Not include | ed on lines 2 5 or | 9) | 0 | 13. |
| .00 0 | Charges for patients covered under state or local indigent care pr | rogram (Not include | d in lines 6 or | 0 | 14. |
| : | 10) | ogram (Not menue | u m mes o or | U | 14. |
| 5.00 9 | State or local indigent care program cost (line 1 times line 14) | | | 0 | 15. |
| 6.00 t | Difference between net revenue and costs for state or local indige | ent care program (1 | ine 15 minus line | ٥ | 16. |
| | | , , | | | |
| | <u>l3;</u> if < zero then enter zero) | | | | |
| U | 13; 1f < zero then enter zero) Incompensated care (see instructions for each line) | | | | |
| 7.00 F | l3; if < zero then enter zero) Incompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to fundi | ng charity care | | 0 | 17. |
| 7.00 F 8.00 G | l3; If < zero then enter zero) Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hose | nital operations | | 0 | |
| 7.00 F 8.00 C 9.00 1 | l3; if < zero then enter zero) Incompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to fundi | nital operations | ams (sum of lines | - | 18. |
| 7.00 F 8.00 C 9.00 1 | ld; If < zero then enter zero) Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid , SCHIP and state and local i | oital operations ndigent care progr | Insured | 0 539,220 Total (col. 1 | 18. |
| 7.00 F 8.00 C 9.00 1 | ld; If < zero then enter zero) Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid , SCHIP and state and local i | oital operations ndigent care progr Uninsured patients | Insured patients | 0 539,220 Total (col. 1 + col. 2) | 18. |
| 7.00 F 8.00 G 9.00 1 | 13; 1f < zero then enter zero) Incompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid , SCHIP and state and local i 3, 12 and 16) | oital operations ndigent care progr Uninsured patients | Insured patients 2.00 | 0 539,220 Total (col. 1 + col. 2) 3.00 | 18. 19. |
| 7.00 F 3.00 C 3.00 T | 13; 1f < zero then enter zero) Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid , SCHIP and state and local i B, 12 and 16) Total initial obligation of patients approved for charity care (at | oital operations ndigent care progr Uninsured patients 1.00 | Insured patients 2.00 | 0 539,220 Total (col. 1 + col. 2) | 18. 19. |
| 7.00 F 3.00 G 9.00 1 | 13; 1f < zero then enter zero) Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid , SCHIP and state and local i B, 12 and 16) Total initial obligation of patients approved for charity care (at | Uninsured patients full 1,915, | Insured patients 2.00 0 | 0 539,220 Total (col. 1 + col. 2) 3.00 1,915,383 | 18. 19. |
| 7.00 F 8.00 C 9.00 T 8.00 C | 13; 1f < zero then enter zero) Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid , SCHIP and state and local i B, 12 and 16) Total initial obligation of patients approved for charity care (at | Uninsured patients full 1,915, | Insured patients 2.00 0 | 0 539,220 Total (col. 1 + col. 2) 3.00 | 18. 19. |
| 7.00 F 3.00 G 3.00 T 8 | 13; 1f < zero then enter zero) Incompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to funding the second secon | Uninsured patients full 1,915, | Insured patients 2.00 0 | 0 539,220 Total (col. 1 + col. 2) 3.00 1,915,383 | 18. 19. 20. |
| 7.00 F 3.00 G 3.00 T 8 | 13; 1f < zero then enter zero) Incompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to funding the second secon | uninsured patients full 1,915, icility Time 1 710,4 | Insured patients 2.00 0 0 | 0 539,220 Total (col. 1 + col. 2) 3.00 1,915,383 710,839 | 18. 19. 20. 21. |
| 7.00 F 3.00 G 3.00 T 8 | Id; 1f < zero then enter zero) Incompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to funding for solvernment grants, appropriations or transfers for support of hose total unreimbursed cost for Medicaid, SCHIP and state and local importance in the solver for the state and local importance in the solver for the solver for the entire factors of initial obligation of patients approved for charity care (at charges excluding non-reimbursable cost centers) for the entire factors of initial obligation of patients approved for charity care (at charges line 20) | Uninsured patients full 1,915, | Insured patients 2.00 0 0 | 0 539,220 Total (col. 1 + col. 2) 3.00 1,915,383 | 18. 19. 20. 21. |
| 7.00 F 3.00 C 2.00 F 3.00 C | Oncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to funding overnment grants, appropriations or transfers for support of hosp total unreimbursed cost for Medicaid, SCHIP and state and local instal and 16) Total initial obligation of patients approved for charity care (at charges excluding non-reimbursable cost centers) for the entire factors of initial obligation of patients approved for charity care (at charges line 20) Partial payment by patients approved for charity care (cost of charity care (line 21 minus line 22) | Uninsured patients full 1,915, cility Time 1 710,8 | Insured patients 2.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 539,220 Total (col. 1 + col. 2) 3.00 1,915,383 710,839 0 710,839 | 18. 19. 20. 21. |
| 7.00 F 3.00 7 8.00 7 1.00 C | Oncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hosp total unreimbursed cost for Medicaid, SCHIP and state and local in the second s | uninsured patients full 1,915, icility Time 1 710,4 | Insured patients 2.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 539,220 Total (col. 1 + col. 2) 3.00 1,915,383 710,839 | 20. 21. 22. |
| 7.00 F 3.00 D 2.00 D 1.00 C | Incompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hosp total unreimbursed cost for Medicaid, SCHIP and state and local instal and 16) Total initial obligation of patients approved for charity care (at charges excluding non-reimbursable cost centers) for the entire factors of initial obligation of patients approved for charity care (at times line 20) Partial payment by patients approved for charity care cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient dat imposed on patients covered by Medicaid or other indigent care pro- | uninsured patients full 1,915, cility line 1 710,4 ys beyond a length | Insured patients 2.00 383 0 0 0 339 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 539,220 Total (col. 1 + col. 2) 3.00 1,915,383 710,839 0 710,839 | 18. 19. 20. 21. |
| 7.00 F 3.00 G 3.00 G 3.00 G | If < zero then enter zero) Incompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hosp total unreimbursed cost for Medicaid, SCHIP and state and local in the second s | uninsured patients full 1,915, cility line 1 710,3 yys beyond a length gram? care program's leng | Insured patients 2.00 383 0 0 0 339 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 539,220 Total (col. 1 + col. 2) 3.00 1,915,383 710,839 0 710,839 | 20. 21. 22. |
| 7.00 F 3.00 C 3.00 C 3.00 C 3.00 C | Oncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hosp total unreimbursed cost for Medicaid, SCHIP and state and local in the second se | uninsured patients full 1,915, cility line 1 710,8 ys beyond a length gram? care program's length rotions) | Insured patients 2.00 383 0 0 0 339 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 539,220 Total (col. 1 + col. 2) 3.00 1,915,383 710,839 0 710,839 1.00 N | 20. 21. 22. 23. |
| 7.00 F 3.00 C 3.00 C 3.00 C 3.00 C 4.00 C | Oncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hosp total unreimbursed cost for Medicaid, SCHIP and state and local in the second se | Uninsured patients 1.00 1,915, 1cility line 1 710,8 720,8 Tys beyond a length gram? care program's lengthis length gram and length gram? | Insured patients 2.00 383 0 0 0 339 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 539,220 Total (col. 1 + col. 2) 3.00 1,915,383 710,839 0 710,839 1.00 N | 20. 21. 22. 23. 24. |
| 2.00 F 3.00 C 3.00 C 3.00 C 3.00 C 4.00 C | Oncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hosp total unreimbursed cost for Medicaid, SCHIP and state and local in the second se | Uninsured patients 1.00 1,915, 1cility line 1 710,8 720,8 Tys beyond a length gram? care program's lengthis length gram and length gram? | Insured patients 2.00 383 0 0 0 339 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 539,220 Total (col. 1 + col. 2) 3.00 1,915,383 710,839 0 710,839 1.00 N | 20. 21. 22. 23. 24. 25. 26. 27. |
| 7.00 F 3.00 C 3.00 C 3.00 T 6.00 C | Incompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hosp total unreimbursed cost for Medicaid, SCHIP and state and local in the second se | ys beyond a length gram? care program's lengths.) In the length of the length gram? care program's length gram; care program's length length gram; care program's length gram; care program's length length gram; care program's length gram; care program's length length gram; care program's length length gram; care program's length | Insured patients 2.00 383 0 0 0 339 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 539,220 Total (col. 1 + col. 2) 3.00 1,915,383 710,839 0 710,839 1.00 N 0 2,858,594 407,479 | 20. 21. 22. 23. 24. 25. 26. 27. 28. |
| 7.00 F 8.00 F 8.00 F 1.00 C 1.00 F 1.00 F | Oncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hosp total unreimbursed cost for Medicaid, SCHIP and state and local in the second se | uninsured patients full 1,915, cility line 1 710,3 ys beyond a length gram? care program's length citions) ns) line 27) | Insured patients 2.00 383 0 0 0 339 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 539,220 Total (col. 1 + col. 2) 3.00 1,915,383 710,839 0 710,839 1.00 N 0 2,858,594 407,479 2,451,115 | 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. |

| Cost Center Description | RECLA | SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (| OF EXPENSES | Provider | | Period: From 01/01/2012 | Worksheet A | |
|--|--|--|-------------|------------|---------------|----------------------------|--------------------------------|--------|
| Cost Center Description | -1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1 | | | | | | Date/Time Pre 5/29/2013 8:0 | pared: |
| Col. 4 C | | Cost Center Description | Salaries | Other | Total (col. 1 | Reclassificati | | Ī |
| Col. 49 Col. 40 Col. | | | | | + col. 2) | ons (See A-6) | Trial Balance | |
| CAMPAIL SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 | | | | | | | | |
| GEMERAL SERVICE COST CENTERS 1.00 395,574 1.00 395,574 1.00 | | | | | | | | |
| 1.00 | | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 2.00 | 1 00 | | | | | | | |
| 0.00400 DOMONO EMPLOYEE BENEFITS 142,167 423,928 566,095 566,101 4.00 | | 00300 NEW CAP REL COSTS-BLDG & FIXT | | | | | | |
| 5.01 005561 OTHER ADMINISTRATIVE AND GENERAL 1,358,188 2,867,266 4,225,449 8,770 4,234,219 5,01 | | 00200 NEW CAP REL COSTS-MVBLE EQUIP | | | | | | |
| 5.00 005600 BUSINESS OFFICE 389,335 580,472 1.069,807 5.02 5.00 00500 MAINTENANCE & REPAIRS 311,675 361,370 673,045 0 673,045 6.00 673,045 6.00 00500 004,0000 MAINTENANCE & 0 0 0 0 0 0 0 0 0 0 | | 00400 EMPLOYEE BENEFITS | | | | | | |
| 0.0060 MAINTENANCE & REPAIRS 311.675 361.370 673.045 6.00 | | | 1 1 | | | | | |
| 1.00 | | | | | | 1 1 | 1,069,807 | |
| 8.00 00800 LANDRY & LINEN SERVICE 0 | | | 1 1 | | | | | |
| 9.00 00900 HOUSEKEEPING 288,206 447,582 735,791 0 735,792 0.00 | | | 0 | | | 5 0 | 527,475 | 7.00 |
| 10.00 01000 | | 00800 LAUNDRY & LINEN SERVICE | 0 | - | , | 1 *1 | 0 | 8.00 |
| 11.00 01.00 01.00 01.00 0 749.101 749.101 11.00 13.00 13.00 13.00 01.300 01.000 01.300 01.000 01. | | | | | | | 735,791 | 9.00 |
| 13.00 01300 NURSING ADMINISTRATION 146, 327 56, 108 202, 435 30 202, 435 11.00 | | | 459,582 | 617,776 | 1,077,358 | | 328,257 | 10.00 |
| 14.00 01400 01400 01400 01400 01400 01400 01400 0150 | 11.00 | 01300 WARETERIA | 0 | 0 | (| | | |
| 15.00 01500 PIARMACY 655, 535 2,229,801 2,885,336 -10,686 2,874,850 15.00 16.00 1600 MEDICAL RECORDS & LIBRARY 335,469 381,863 717,332 0 717,332 15.00 717 | 13.00 | 01300 NURSING ADMINISTRATION | | • | | | 202,435 | 13.00 |
| 16.00 | 14.00 | 01400 CENTRAL SERVICES & SUPPLY | | | | 2 0 | 1,090,282 | 14.00 |
| TINPATTENT ROUTINE SERVICE COST CENTERS 1,678,963 662,014 2,340,977 0 2,340,977 30.00 43.00 000 0 0 0 0 0 0 0 | 15.00 | 01500 PHARMACY | | | | | 2,874,650 | 15.00 |
| 30.00 03000 ADULTS & PEDIATRICS 1,678,963 662,014 2,340,977 0 2,340,977 30.00 | 10.00 | U16UU MEDICAL RECORDS & LIBRARY | 335,469 | 381,863 | 717,332 | 20 | 717,332 | 16.00 |
| 43.00 04300 NURSERY 0 | 20.00 | INPATIENT ROUTINE SERVICE COST CENTERS | · | | | | | |
| 44.00 04400 SATILLED NURSING FACTILITY 597,765 337,399 935,158 0 935,158 44.00 | | | 1,678,963 | 662,014 | 2,340,977 | 0 | 2,340,977 | 30.00 |
| NACTILIARY SERVICE COST CENTERS S0.00 COST. CENT | | | 0 | 0 | (| | | |
| 50.00 0500 | 44.00 | U44UU SKILLED NURSING FACILITY | 597,765 | 337,393 | 935,158 | 3 0 | 935,158 | 44.00 |
| \$51.00 05100 RECOVERY ROOM 69,967 24,318 94,285 0 94,285 51.00 \$52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | EO 00 | | | | | | | |
| 52.00 05200 DELLYERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0 | | | | | | | 1,434,561 | 50.00 |
| 53.00 05300 ANESTHESIOLOGY 722,440 490,010 1,212,450 0 1,212,450 53.00 54.00 05400 ADDIOLOGY-DIAGNOSTIC 713,726 1,291,815 2,005,541 0 2,005,541 54.00 05600 ADDIOLOGY-DIAGNOSTIC 713,726 1,291,815 2,005,541 0 2,005,541 56.00 05600 ADDIOLOGY-DIAGNOSTIC 733,035 1,261,571 1,994,606 0 1,994,606 60.00 60.00 60.00 5000 | | | 1 | 24,318 | 94,285 | 5 0 | 94,285 | 51.00 |
| 54.00 05400 RADIOLOGY-DIAGNOSTIC 713,726 1,291,815 2,005,541 0 2,005,541 54.00 | 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 1 | 0 | (| 0 | 0 | 52.00 |
| 56.00 05600 RADIOISOTOPE 85,732 133,179 218,911 0 218,911 56.00 | 54.00 | 05400 BARTOLOGY BTACHOSTTC | | | | 1 | | |
| 60.00 06000 LABORATORY 733,035 1,261,571 1,994,606 0 1,994,606 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 109,058 109,058 0 109,058 63.00 66.00 06600 PHYSICAL THERAPY 864,100 442,720 1,306,820 0 1,306,820 66.00 67.00 06900 ELECTROCARDIOLOGY 523,228 301,929 825,157 0 825,157 0 825,157 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 724,212 724,212 0 724,212 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 134,596 134,596 0 134,596 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 56.00 | 05600 BADTOTSOTORE | | | | | | 1 |
| 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 109,058 109,058 0 109,058 63.00 66.00 06600 PHYSICAL THERAPY 864,100 442,720 1,306,820 0 1,306,820 66.00 71.00 06900 ELECTROCARDIOLOGY 523,228 301,929 825,157 0 822,157 72.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 724,212 724,212 0 724,212 724,212 0 724,212 724,212 0 724,212 724,212 0 724,212 724,212 0 724,212 724,212 0 72 | | | | , , | | | | |
| 66.00 06600 PHYSICAL THERAPY 864,100 442,720 1,306,820 0 1,306,820 66.00 69.00 06900 ELECTROCARDIOLOGY 523,228 301,929 825,157 0 825,157 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 724,212 724,212 0 724,212 71.00 73.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 134,596 134,596 0 134,596 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73.00 07900 CLINIC 0 179,571 179,571 0 179,571 90.01 09001 SENIOR CARE 132,826 136,520 269,346 0 269,346 0 91.00 09100 EMERGENCY 818,040 2,752,257 3,570,297 0 3,570,297 91.00 92.00 0956RVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 70 07HER REIMBURSABLE COST CENTERS 101.00 HOSPICE 373,674 406,010 779,684 0 44,712 133,563 0 134,871,279 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 0 192.00 19200 PHYSICAL HYDER SCIENT 0 12,949,027 21,922,246 34,871,273 6 34,871,279 118.00 194.00 07950 FITNESS CENTER 2 845,903 2,163,313 5,009,216 0 5,009,216 192.00 194.01 07951 MARKETING 63,093 120,185 183,278 0 183,278 194.01 194.02 07952 NEW DIRECTION 0 0 0 0 0 0 194.03 07953 RESPITE 0 0 0 0 0 0 0 194.03 07950 FITNESS CENTER 18,404 18,88,849 44,714 133,563 0 133,563 194.00 194.04 07954 WELL CHILL CLINIC 88,8849 44,714 133,563 0 133,563 194.00 194.04 07954 WELL CHILL CLINIC 88,8849 44,714 133,563 0 133,563 194.00 | 63.00 | 06300 BLOOD STORTNE BROCESSTNE & TRANS | /33,035 | | | | | |
| 69.00 06900 ELECTROCARDIOLOGY 523,228 301,929 825,157 0 825,157 69.00 | 66.00 | 06600 BUYSTON THERABY | 004 100 | | | | | |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 724,212 724,212 0 724,212 724 | 69 00 | 06900 FITSICAL THERAPY | 1 | | | | | |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 134,596 0 0 0 0 0 0 0 0 0 | 71 00 | 07100 MEDICAL SUPPLIES CHARCED TO DATTEMES | 523,228 | | | | | |
| 073.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 | 72.00 | 07200 TMPL DEV CHARGED TO PATIENTS | 0 | | | | | |
| 90.00 09000 CLINIC 0 179,571 179,571 0 179,571 90.00 09001 SENIOR CARE 132,826 136,520 269,346 0 269,346 90.01 09001 SENIOR CARE 132,826 136,520 269,346 0 269,346 90.01 09001 SERVATION BEDS (NON-DISTINCT PART) 0 3,570,297 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 010100 HOMBE HEALTH AGENCY 823,646 540,435 1,364,081 0 1,364,081 101.00 SPECIAL PURPOSE COST CENTERS 16.00 11600 HOSPICE 373,674 406,010 779,684 0 779,684 116.00 SUBTOTALS (SUM OF LINES 1-117) 12,949,027 21,922,246 34,871,273 6 34,871,279 118.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 28 13 41 -6 35 194.00 194.00 07955 FITNESS CENTER 28 13 41 -6 35 194.00 194.00 07955 NEW DIRECTION 0 0 0 0 0 0 0 0 0 | 73.00 | 07300 DRIGS CHARGED TO PATTENTS | 0 | | | 1 | | |
| 90.00 09000 CLINIC 0 179,571 179,571 0 179,571 90.00 90.00 90.00 58NIOR CARE 132,826 136,520 269,346 0 269,346 90.01 90.00 90.00 68ERGENCY 92.00 09200 08SERVATION BEDS (NON-DISTINCT PART) 91.00 92.00 08SERVATION BEDS (NON-DISTINCT PART) 92.00 07HER REIMBURSABLE COST CENTERS 101.00 Home Health Agency 823,646 540,435 1,364,081 0 1,364,081 101.00 16 | 73.00 | OUTPATTENT SERVICE COST CENTERS | JU | 0 | (| 0 | 0 | 73.00 |
| 90.01 09001 SENIOR CARE 132,826 136,520 269,346 0 269,346 90.01 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 92.00 101.00 HOME HEALTH AGENCY 823,646 540,435 1,364,081 0 1,364,081 101.00 101.00 HOME HEALTH AGENCY 92.00 101.00 Hospice 373,674 406,010 779,684 0 779,684 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 12,949,027 21,922,246 34,871,273 6 34,871,279 118.00 118.00 192.00 | 90.00 | | | 470 574 | 4 = 0 | | | |
| 91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 3,570,297 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 0 3,570,297 91.00 92.00 OTHER REIMBURSABLE COST CENTERS 0 1,364,081 0 1,364,081 101.00 OTHER REIMBURSABLE COST CENTERS 0 16.00 16.00 16.00 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 | | 09001 SENTOR CARE | | | | | | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 91.00 92.00 OTHER REIMBURSABLE COST CENTERS 92.00 OTHER REIMBURSABLE COST CENTERS 92.00 OTHER REIMBURSABLE COST CENTERS OTHER SPECIAL PURPOSE COST CENTERS 116.00 11600 HOME HEALTH AGENCY 823,646 540,435 1,364,081 O 1,364,081 101.00 OTHER SPECIAL PURPOSE COST CENTERS 373,674 406,010 779,684 0 779,684 116.00 OTHER SUBTOTALS (SUM OF LINES 1-117) 12,949,027 21,922,246 34,871,273 OTHER SUBTOTALS (SUM OF LINES 1-117) 12,949,027 21,922,246 34,871,273 OTHER SUBTOTALS (SUM OF LINES 1-117) 12,949,027 21,922,246 34,871,273 OTHER SUBTOTALS (SUM OF LINES 1-117) 12,949,027 21,922,246 34,871,273 OTHER SUBTOTALS (SUM OF LINES 1-117) 12,949,027 21,922,246 34,871,273 OTHER SUBTOTALS (SUM OF LINES 1-117) 12,949,027 21,922,246 34,871,273 OTHER SUBTOTALS (SUM OF LINES 1-117) 12,949,027 21,922,246 34,871,273 OTHER SUBTOTALS (SUM OF LINES 1-117) 12,949,027 21,922,246 34,871,273 OTHER SUBTOTALS (SUM OF LINES 1-117) 12,949,027 21,922,246 34,871,273 OTHER SUBTOTALS (SUM OF LINES 1-117) 12,949,027 21,922,246 34,871,273 OTHER SUBTOTALS (SUM OF LINES 1-117) 12,949,027 21,922,246 34,871,273 OTHER SUBTOTALS (SUM OF LINES 1-117) 12,949,027 21,922,246 34,871,273 OTHER SUBTOTALS (SUM OF LINES 1-117) 12,949,027 21,922,246 34,871,273 OTHER SUBTOTALS (SUM OF LINES 1-117) 12,949,027 21,922,246 34,871,273 OTHER SUBTOTALS (SUM OF LINES 1-117) 12,949,027 21,922,246 34,871,273 OTHER SUBTOTALS (SUM OF LINES 1-118 1-100) 190.00 0 0 0 0 0 0 0 0 0 | 91 00 | 09100 EMERGENCY | | , | | | | |
| 101.00 10100 HOME HEALTH AGENCY 823,646 540,435 1,364,081 0 1,364,081 101.00 | 92 00 | 09200 OBSERVATION REDS (NON-DISTINCT DART) | 818,040 | 2,752,257 | 3,5/0,29/ | 0 | 3,570,297 | 1 |
| 101.00 10100 HOME HEALTH AGENCY S23,646 540,435 1,364,081 0 1,364,081 101.00 160 | 32.00 | OTHER RETURNINGARIE COST CENTERS | L | | | <u> </u> | | 92.00 |
| SPECIAL PURPOSE COST CENTERS 373,674 406,010 779,684 16.00 179,684 116.00 18.00 SUBTOTALS (SUM OF LINES 1-117) 12,949,027 21,922,246 34,871,273 6 34,871,279 118.00 190.0 | 101.00 | 10100 HOME HEALTH ACENCY | 922 646 | | 1 364 001 | | | |
| 116.00 11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117) 12,949,027 21,922,246 34,871,273 6 34,871,279 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 2,845,903 2,163,313 5,009,216 0 5,009,216 192.00 194.00 07950 FITNESS CENTER 28 13 41 -6 35 194.00 194.01 07951 MARKETING 63,093 120,185 183,278 0 183,278 194.01 194.02 07952 NEW DIRECTION 0 0 0 0 0 0 194.03 194.03 107953 RESPITE 0 0 0 0 0 0 0 0 194.03 194.04 07954 WELL CHILD CLINIC 88,849 44,714 133,563 0 133,563 194.04 | | SPECTAL PURPOSE COST CENTERS | 023,040 | 340,433 | 1,364,081 | 0 | 1,364,081 | 101.00 |
| 118.00 SUBTOTALS (SUM OF LINES 1-117) 12,949,027 21,922,246 34,871,273 6 34,871,279 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 2,845,903 2,163,313 5,009,216 0 5,009,216 192.00 194.00 07950 FITNESS CENTER 28 13 41 -6 35 194.00 194.01 07951 MARKETING 63,093 120,185 183,278 0 183,278 194.01 194.02 07952 NEW DIRECTION 0 0 0 0 194.02 194.03 07953 RESPITE 0 0 0 0 0 0 194.02 194.04 07954 WELL CHILD CLINIC 88,849 44,714 133,563 0 133,563 194.04 | 116.00 | 11600 HOSPICE | 373 (74 | 406 010 | 770 60 | | | |
| NONREIMBURSABLE COST CENTERS 190.00 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 192.00 192.00 192.00 192.00 192.00 FITNESS CENTER 28 13 41 -6 35 194.00 194.01 194.01 195.00 194.02 195.00 | | | 12 010 00- | | | | | |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 2,845,903 2,163,313 5,009,216 0 5,009,216 192.00 194.00 07950 FITNESS CENTER 28 13 41 -6 35 194.00 194.01 07951 MARKETING 63,093 120,185 183,278 0 183,278 194.01 194.02 07952 NEW DIRECTION 0 0 0 0 194.02 194.03 07953 RESPITE 0 0 0 0 0 194.02 194.04 07954 WELL CHILD CLINIC 88,849 44,714 133,563 0 133,563 194.04 | | NONRETMRURSARI E COST CENTERS | 12,949,027 | 21,922,240 | 34,8/1,2/3 | <u> </u> | 34,871,279 | 118.00 |
| 192.00 19200 PHYSICIANS' PRIVATE OFFICES 2,845,903 2,163,313 5,009,216 0 5,009,216 192.00 194.00 07950 FITNESS CENTER 28 13 41 -6 35 194.00 194.02 07952 NEW DIRECTION 0 0 0 0 194.02 194.03 07953 RESPITE 0 0 0 0 0 0 194.02 194.04 07954 WELL CHILD CLINIC 88,849 44,714 133,563 0 133,563 194.04 | 190.00 | 19000 GTET. FLOWER COFFEE SHOP & CANTEEN | | | | | | |
| 194.00 07950 FITNESS CENTER 28 13 41 -6 35 194.00 194.01 07951 MARKETING 63,093 120,185 183,278 0 183,278 194.01 194.03 07952 NEW DIRECTION 0 0 0 0 194.02 194.04 07954 WELL CHILD CLINIC 88,849 44,714 133,563 0 133,563 194.04 194.04 07954 WELL CHILD CLINIC 88,849 44,714 133,563 0 133,563 194.04 | 192.00 | 19200 PHYSTCIANS' PRIVATE DEETCES | | 2 162 212 | F 000 310 | 0 | | |
| 194.01 07951 MARKETING 63,093 120,185 183,278 0 183,278 194.01 194.02 07952 NEW DIRECTION 0 0 0 0 0 194.02 194.03 07953 RESPITE 0 0 0 0 0 0 0 194.03 194.04 07954 WELL CHILD CLINIC 88,849 44,714 133,563 0 133,563 194.04 | 194.00 | 07950 FITNESS CENTER | | | | 1 1 | | |
| 194.02 07952 NEW DIRECTION 0 0 0 194.02 194.03 07953 RESPITE 0 0 0 0 0 194.03 194.04 07954 WELL CHILD CLINIC 88,849 44,714 133,563 0 133,563 194.04 | | | | | | | 35 | 194.00 |
| 194.03 07953 RESPITE 0 0 0 0 0 194.03 194.04 07954 WELL CHILD CLINIC 88,849 44,714 133,563 0 133,563 194.04 | 194.02 | 07952 NEW DIRECTION | 03,093 | | 183,2/8 | 1 | | |
| 194.04 07954 WELL CHILD CLINIC 88,849 44,714 133,563 0 133,563 194.04 | 194.03 | 07953 RESPITE | Ú | - 1 | 0 | | | |
| 200 00 TOTAL (SUM OF LINES 118 100) | | | 00 040 | -1 | 122.55 | | | |
| 13,940,900 24,250,471 40,197,371 0 40,197,371 200.00 | 200.00 | TOTAL (SUM OF LINES 118-199) | | | | | | |
| | | , | 13,340,900 | 24,230,4/1 | 40,197,371 | .i O ∤ | 40,197,371 | 200.00 |

| | | | To 12/31/2012 Date/Time Pre | pared |
|--|-------------|----------------|--|------------------------|
| Cost Center Description | Adjustments | Net Expenses | 5/29/2013 8:03 | s am |
| | (See A-8) | For Allocation | | |
| | 6.00 | 7.00 | | |
| GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-RIDG & ETYT | | | | Planting of the co. of |
| THE COSTS BLOG & TIXT | -43,895 | | The state of the s | 1. |
| THE COSTS HADEL EQUIT | -451,787 | | | 2. |
| 4.00 00400 EMPLOYEE BENEFITS | -1,950 | 564,151 | | 4. |
| 5.01 00561 OTHER ADMINISTRATIVE AND GENERAL | -343,883 | 3,890,336 | | 5. |
| 5.02 00560 BUSINESS OFFICE | 0 | 1,069,807 | | 5. |
| 6.00 00600 MAINTENANCE & REPAIRS | -409 | 672,636 | | 6. |
| 7.00 00700 OPERATION OF PLANT | -8,555 | 518,920 | | 7. |
| 3.00 00800 LAUNDRY & LINEN SERVICE | 0 | 0 | | 8. |
| 0.00 00900 HOUSEKEEPING | 0 | 735,791 | | 9. |
| 10.00 01000 DIETARY | o | | | 10. |
| 1.00 01100 CAFETERIA | -229,954 | | | |
| 13.00 01300 NURSING ADMINISTRATION | 0 | 202,435 | | 11. |
| L4.00 01400 CENTRAL SERVICES & SUPPLY | -1,405 | 1,088,877 | | 13. |
| .5.00 01500 PHARMACY | -113,299 | 2,761.351 | | 14. |
| 6.00 01600 MEDICAL RECORDS & LIBRARY | -16,360 | | | 15. |
| INPATIENT ROUTINE SERVICE COST CENTERS | | 700,972 | | 16. |
| 0.00 03000 ADULTS & PEDIATRICS | -260,026 | 2 000 051 | The second section of the second section is a second section of the second section of the second section of the second section | |
| 3.00 04300 NURSERY | -200,020 | 2,080,951 | | 30. |
| 4.00 04400 SKILLED NURSING FACILITY | o | 025 150 | | 43. |
| ANCILLARY SERVICE COST CENTERS | | 935,158 | | 44. |
| 0.00 05000 OPERATING ROOM | 0 | 1 424 561 | | |
| 1.00 05100 RECOVERY ROOM | - 1 | 1,434,561 | | 50. |
| 2.00 05200 DELIVERY ROOM & LABOR ROOM | 0 | 94,285 | | 51. |
| 3.00 05300 ANESTHESIOLOGY | 1 164 015 | 0 | | 52. |
| 4.00 05400 RADIOLOGY-DIAGNOSTIC | -1,164,015 | 48,435 | | 53. |
| 6.00 05600 RADIOISOTOPE | -397 | 2,005,144 | | 54. |
| 0.00 06000 LABORATORY | 0 | 218,911 | | 56. |
| 3.00 06300 BLOOD STORING, PROCESSING & TRANS. | -14,735 | 1,979,871 | | 60. |
| 6.00 06600 PHYSICAL THERAPY | 0 | 109,058 | | 63. |
| 9.00 06900 ELECTROCARDIOLOGY | 0 | 1,306,820 | | 66. |
| 1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN | -78,244 | 746,913 | | 69. |
| 2.00 07200 IMPL. DEV. CHARGED TO PATIENT | | 724,212 | i | 71. |
| 3.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 134,596 | | 72. |
| OUTDATTENT SERVICE COST | 0 | 0 | 1 | 73. |
| OUTPATIENT SERVICE COST CENTERS 0.00 09000 CLINIC | | | | |
| 0.01 09000 CEINIC 0.01 09001 SENIOR CARE | 0 | 179,571 | | 90. |
| L OO OOLOO SUEDCENSO | 0 | 269,346 | 4 | 90. |
| 00 09100 EMERGENCY | -1,458,691 | 2,111,606 | | 91. |
| 2.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR | τ) [| | i i | 92. |
| OTHER REIMBURSABLE COST CENTERS | | | And the same of th | J |
| 1.00 10100 HOME HEALTH AGENCY | 0 | 1,364,081 | 1 | .01. |
| SPECIAL PURPOSE COST CENTERS | | | | OI. |
| L6.00 11600 HOSPICE | 0 | 779,684 | 1 | 16. |
| L8.00 SUBTOTALS (SUM OF LINES 1-117) | -4,187,605 | 30,683,674 | | 18. |
| NONREIMBURSABLE COST CENTERS | | | | 10. |
| 0.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | | 00 / |
| 2.00 19200 PHYSICIANS' PRIVATE OFFICES | 0 | 5,009,216 | | 90. |
| 4.00 07950 FITNESS CENTER | o | 35 | i e | 92. |
| 4.01 07951 MARKETING | 0 | 183,278 | 1 | 94. |
| 4.02 07952 NEW DIRECTION | 0 | 0 | | 94. |
| 4.03 07953 RESPITE | n | o | | 94.(|
| 4.04 07954 WELL CHILD CLINIC | 0 | 133,563 | | 94.(|
| 0.00 TOTAL (SUM OF LINES 118-199) | -4,187,605 | 36,009,766 | | 94.(|
| | 1,107,000 | 30,003,700 | [20 | 00.0 |

| OST (| ENTERS USED IN COST REPORT | Provider | CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet Date/Time 5/29/2013 | Prepare |
|--------|--|--|----------------|--|--|---------|
| | Cost Center Description | | CMS Code | Standard Non-Stand | Label For | |
| | | | 1.00 | 2. | 00 | |
| | GENERAL SERVICE COST CENTERS | electrical distribution de la company de la company de la company de la company de la company de la company de | | | | |
| .00 | NEW CAP REL COSTS-BLDG & FIXT | | 00100 | manufacture of Authorities (Authorities Control of Authorities Contr | THE RESERVE THE PERSON NAMED IN COLUMN TWO | 1 |
| .00 | NEW CAP REL COSTS-MVBLE EQUIP | | 00200 | | | 2 |
| .00 | EMPLOYEE BENEFITS | | 00400 | | | 4 |
| .01 | OTHER ADMINISTRATIVE AND GENERAL | | 00561 | | | 5 |
| .02 | BUSINESS OFFICE | | 00560 | | | 5 |
| .00 | MAINTENANCE & REPAIRS | | 00600 | | | 6 |
| .00 | OPERATION OF PLANT | | 00700 | | | 7 |
| .00 | LAUNDRY & LINEN SERVICE | | 00800 | | | 8 |
| .00 | HOUSEKEEPING | - | 00900 | | | 9 |
| 0.00 | DIETARY | 1 | 01000 | | | 10 |
| 1.00 | CAFETERIA | 1 | 01100 | | | 11 |
| | NURSING ADMINISTRATION | | 01300 | | | 13 |
| 1.00 | CENTRAL SERVICES & SUPPLY | | 01400 | | | 14 |
| | PHARMACY | | 01500 | | | 15 |
| 0.00 | MEDICAL RECORDS & LIBRARY | | 01600 | | | 16 |
| ٠. ٥٥ | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | |
| | ADULTS & PEDIATRICS | | 03000 | | | 30 |
| | NURSERY | | 04300 | | | 43 |
| 1.00 | SKILLED NURSING FACILITY | | 04400 | | | 44 |
| οó | ANCILLARY SERVICE COST CENTERS OPERATING ROOM | | 0.500 | | · | |
| | RECOVERY ROOM | i | 05000 | | | 50 |
| | DELIVERY ROOM & LABOR ROOM | | 05100 | | | 51 |
| | ANESTHESIOLOGY | | 05200 | | | 52 |
| | RADIOLOGY-DIAGNOSTIC | | 05300 | | | 53 |
| | RADIOISOTOPE | | 05400 | | | 54 |
| 0.00 | LABORATORY | | 05600 | | | 56 |
| | BLOOD STORING, PROCESSING & TRANS. | | 06000 | | | 60 |
| 5.00 | PHYSICAL THERAPY | | 06300 | | | 63 |
| | ELECTROCARDIOLOGY | | 06600 06900 | | | 66 |
| | MEDICAL SUPPLIES CHARGED TO PATIENTS | | 07100 | | | 69 |
| | IMPL. DEV. CHARGED TO PATIENT | | 07200 | | | 71 |
| .00 | DRUGS CHARGED TO PATIENTS | | 07200 | | | 72 |
| • | OUTPATIENT SERVICE COST CENTERS | | 07300 | | | 73 |
| .00 | CLINIC | | 09000 | | | 90 |
| .01 | SENIOR CARE | | 09001 | | | 90 |
| | EMERGENCY | | 09100 | | | 91 |
| .00 | OBSERVATION BEDS (NON-DISTINCT PART) | | 09200 | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | J | | - t | | |
| 1.00 | HOME HEALTH AGENCY | | 10100 | | | 101 |
| | SPECIAL PURPOSE COST CENTERS | | | | | |
| | HOSPICE | I | 11600 | | | 116 |
| 8.00 | SUBTOTALS (SUM OF LINES 1-117) | | | | | 118 |
| | NONREIMBURSABLE COST CENTERS | | | | | |
| 0.00 | GIFT, FLOWER, COFFEE SHOP & CANTEEN | | 19000 | | | 190 |
| 2.00 | PHYSICIANS' PRIVATE OFFICES | | 19200 | | | 192 |
| | FITNESS CENTER | | 07950 | | | 194 |
| | MARKETING | | 07951 | | | 194 |
| | NEW DIRECTION | | 07952 | | | 194 |
| | RESPITE | | 07953 | | | 194 |
| 4.04 | WELL CHILD CLINIC | | 07954 | | | 194 |
| .). 00 | TOTAL (SUM OF LINES 118-199) | | | | | 200 |

| | n Financial Systems SSIFICATIONS | | WABASH COUNTY | | | In Lieu | of Form CMS | 5-2552-10 |
|---|----------------------------------|--|---------------|----------|--|--|-------------|-----------|
| RECEA | 351F1CATIONS | | | Provider | CCN: 151310 | Period: From 01/01/2012 | Worksheet A | |
| | | | | | | To 12/31/2012 | Date/Time P | repared: |
| | | Increases | | | | | 5/29/2013 8 | :08 am |
| *************************************** | Cost Center | Line # | Salary | Other | | | | |
| | 2.00 | 3.00 | 4.00 | 5.00 | | | | |
| | A - CAFETERIA | The second secon | | 3.00 | | | | |
| 1.00 | CAFETERIA | 11.00 | 319,553 | 429,548 | | the second secon | | |
| | TOTALS | | 319,553 | 429,548 | | | | 1.00 |
| | B - TUMOR REGISTRY | | | 723,370 | | | | |
| 1.00 | OTHER ADMINISTRATIVE AND | 5.01 | 0 | 10,686 | | | | |
| | GENERAL | | ٩ | 10,000 | | | | 1.00 |
| | TOTALS | | | 10,686 | | | | |
| | E - INTEREST | | <u> </u> | 10,000 | No. of the last of | | | 4 |
| 1.00 | NEW CAP REL COSTS-MVBLE | 2,00 | 0 | 1,916 | COMMENT OF THE PROPERTY OF THE | | | |
| | EQUIP | 00 | ٩ | 1,510 | | | | 1.00 |
| | TOTALS | | | 1,916 | | | | |
| | F - FITNESS CENTER | Andrew Control of the | | | | | | |
| 1.00 | EMPLOYEE BENEFITS | 4.00 | 1 | 7 | | | | _ |
| | TOTALS | | - | | | | | 1.00 |
| 500.00 | Grand Total: Increases | | 319,557 | 442 152 | | | | |
| | | ' | 313,337 | 442,152 | | | | 500.00 |

| Health | Financial Systems | | WABASH COUNTY | HOSPITAL | | In Lie | of Form CMS | -2552-10 |
|---|----------------------------------|--|---|----------|---|---|--|----------|
| RECLAS | SIFICATIONS | | | Provider | CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A | repared: |
| | | Decreases | Marity and the second | | T************************************* | | 5/29/2013 8 | :08 am |
| | Cost Center | Line # | Salary | Other | Wkst. A-7 Ref | :1 | | |
| *************************************** | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | 1 | | İ |
| | A - CAFETERIA | To be the second of the second | Marie Control of the | | | | | |
| 1.00 | DIETARY | 10.00 | 319,553 | 429,548 | | 0 | | 1.00 |
| | TOTALS | | 319,553 | 429,548 | | | | |
| | B - TUMOR REGISTRY | | | | *************************************** | | | |
| 1.00 | PHARMACY | 15.00 | 0 | 10,686 | | 0 | | 1.00 |
| | TOTALS | | 0 | 10,686 | | | | |
| | E - INTEREST | | | | | | | |
| 1.00 | OTHER ADMINISTRATIVE AND GENERAL | 5.01 | 0 | 1,916 | | 9 | The State of | 1.00 |
| | TOTALS | | 0 | 1,916 | | 7 | | |
| | F - FITNESS CENTER | | | | | - to re- | | 1 |
| 1.00 | FITNESS CENTER | 194.00 | 4 | 2 | | 0 | | 1.00 |
| | TOTALS | | 4 | 2 | | | | |
| 500.00 | Grand Total: Decreases | | 319,557 | 442,152 | | | | 500.00 |

| Health | Financial Systems | | WABASH COUNT | Y HOSPITAL | In Lie | u of Form CMS-2 | 2552-10 |
|--|--------------------------|--|--------------|-------------------------|---|--|----------------|
| RECLAS | SSIFICATIONS | | | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-6 Non-CMS Works Date/Time Pre 5/29/2013 8:0 | heet pared: |
| No. of Contract of | Incr | eases | | Dec | reases | | |
| | Cost Center | Line # | Salary | Cost Center | Line # | Salary | - |
| | 2.00 | 3.00 | 4.00 | 6.00 | 7.00 | 8.00 | |
| | A - CAFETERIA | | **** | | | | |
| 1.00 | CAFETERIA | 11.00 | 319,553 | DIETARY | 10.00 | 319,553 | 1.00 |
| | TOTALS | | 319,553 T | OTALS | | 319,553 | |
| | B - TUMOR REGISTRY | the second secon | | | | 323,333 | |
| 1.00 | OTHER ADMINISTRATIVE AND | 5.01 | 0 P | PHARMACY | 15.00 | 0 | 1.00 |
| | GENERAL | | | | | | |
| | TOTALS | | 0 т | OTALS | | 0 | |
| | E - INTEREST | | | | | | |
| 1.00 | NEW CAP REL COSTS-MVBLE | 2.00 | 00 | THER ADMINISTRATIVE AND | 5.01 | | 1.00 |
| | EQUIP | | G | SENERAL. | | - | |
| | TOTALS | | 0т | OTALS | | 0. | |
| | F - FITNESS CENTER | | | 41 | | | |
| 1.00 | EMPLOYEE BENEFITS | 4.00 | 4 F | ITNESS CENTER | 194.00 | 4 | 1.00 |
| | TOTALS | | 4 T | OTALS | | 4 | _100 |
| 500.00 | Grand Total: Increases | | 319,557 G | rand Total: Decreases | | 319,557 | 500.00 |

| MARKET MARKET CONT. CO. CO. | | | | | To 12/31/2012 | | pared: |
|-----------------------------|---|-----------------------|--|--------------|---------------|--|------------------------|
| | | | | Acquisitions | | | |
| | | Beginning Balances | Purchases | Donation | Total | Disposals and Retirements | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 1.00 | PART I - ANALYSIS OF CHANGES IN CAPITAL A | | | | | Butter to the second of the se | White the second color |
| 2.00 | | 475,705 | 819,309 | | 0 819,309 | 0 | 1.00 |
| 3.00 | Land Improvements | 314,699 | 0 | | 0 | 0 | 2.00 |
| | Buildings and Fixtures | 14,236,782 | 972,015 | | 0 972,015 | Ō | 3.00 |
| 4.00 | Building Improvements | 3,635,918 | 23,474 | | 0 23,474 | | 4.00 |
| 5.00 | Fixed Equipment | 845,994 | 0 | | 0 0 | ő | 5.00 |
| 6.00 | Movable Equipment | 12,008,261 | 466,118 | | 0 466,118 | ñ | 6.00 |
| 7.00 | HIT designated Assets | 0 | 0 | | 0 0 | ň | 7.00 |
| 8.00 | Subtotal (sum of lines 1-7) | 31,517,359 | 2,280,916 | 1 | 0 2,280,916 | 0 | 8.00 |
| 9.00 | Reconciling Items | 0 | 0 | 1 | 0 | 0 | 9.00 |
| 10.00 | Total (line 8 minus line 9) | 31,517,359 | 2,280,916 | | 0 2,280,916 | 0 | 10.00 |
| | | Ending Balance | Fully | | | | 10.00 |
| | | | Depreciated | | | | |
| | | | Assets | | | | |
| | | 6.00 | 7.00 | | | | |
| 1 00 | PART I - ANALYSIS OF CHANGES IN CAPITAL A | SSET BALANCES | A STATE OF THE PARTY OF THE PAR | | | | |
| 1.00 | Land | 1,295,014 | o[| | | The second secon | 1.00 |
| 2.00 | Land Improvements | 314,699 | 0 | | | | 2.00 |
| 3.00 | Buildings and Fixtures | 15,208,797 | 0 | | | | 3.00 |
| 4.00 | Building Improvements | 3,659,392 | 0 | | | | 4.00 |
| 5.00 | Fixed Equipment | 845,994 | 0 | | | | 5.00 |
| 6.00 | Movable Equipment | 12,474,379 | 0 | | | | 6.00 |
| 7.00 | HIT designated Assets | 0 | ol | | | | 7.00 |
| 8.00 | Subtotal (sum of lines 1-7) | 33,798,275 | 0 | | | | 8.00 |
| 9.00 | Reconciling Items | 0 | 0 | | | | |
| 10.00 | Total (line 8 minus line 9) | 33,798,275 | ő | | | | $9.00 \\ 10.00$ |

| | n Financial Systems | WABASH COUNT | TY HOSPITAL | | In Lie | u of Form CMS- | 2552-10 |
|-------|--|---|-------------------|---|---|----------------|--|
| RECON | CILIATION OF CAPITAL COSTS CENTERS | on an addition of an addition of the additional and a second or a | | CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | | pared: |
| | | | Su | IMMARY OF CAP | PITAL | | |
| | Cost Center Description | Depreciation | Lease | Interest | Insurance (see instructions) | | |
| | DADT TT DECONCT! TATTON OF MICH. | 9.00 | 10.00 | 11.00 | 12.00 | 13.00 | and the second and second as the second as t |
| 1.00 | PART II - RECONCILIATION OF AMOUNTS FROM W | | | nd 2 | | | |
| | NEW CAP REL COSTS-BLDG & FIXT | 395,574 | 0 | | 0 0 | 0 | 1.00 |
| 2.00 | NEW CAP REL COSTS-MVBLE EQUIP | 1,205,983 | 0 | | 0 | 0 | 2.00 |
| 3.00 | Total (sum of lines 1-2) | 1,601,557 | l ol | | 0 | 0 | 3.00 |
| | | SUMMARY O | F CAPITAL | e de la companya del la companya de | <u></u> | | 3.00 |
| | Cost Center Description | Other | Total (1) (sum | | | | |
| | | Capital-Relate | | | | | |
| | | d Costs (see | through 14) | | | | |
| | | instructions) | | | | | |
| | | 14.00 | 15.00 | | | | |
| | PART II - RECONCILIATION OF AMOUNTS FROM W | DRKSHEET A COLUM | IN 7 I THE C 1 ar | .d) | | | |
| 1.00 | NEW CAP REL COSTS-BLDG & FIXT | O | | <u> </u> | | | |
| 2.00 | NEW CAP REL COSTS-MVBLE EQUIP | 0 | 395,574 | | | | 1.00 |
| 3.00 | Total (sum of lines 1-2) | ٥ | 1,205,983 | | | | 2.00 |
| | , | 1 0 | 1,601,557 | | | | 3.00 |

| RECON | CILIATION OF CAPITAL COSTS CENTERS | | Provider | CCN: 151310 | Period: | Worksheet A-7 | 2552-1 |
|-------|--|--|----------------|----------------|-----------------|----------------|------------------------|
| | The state of the s | | riovidei | | From 01/01/2012 | Part III | |
| | | | | | To 12/31/2012 | | pared: |
| | | | | | | 5/29/2013 8:0 | 8 am |
| | | СОМ | PUTATION OF RA | TIOS | ALLOCATION OF | OTHER CAPITAL | |
| | Cost Center Description | Gross Assets | Capitalized | Gross Assets | Ratio (see | Insurance | |
| | | 1 | Leases | for Ratio | instructions) | | |
| | | ļ | | (col. 1 - col | | | |
| | | | | 2) | | | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | PART III - RECONCILIATION OF CAPITAL CO | | | | | | |
| 1.00 | NEW CAP REL COSTS-BLDG & FIXT | 395,574 | · 0 | 395,57 | 4 0.246993 | 0 | 1.0 |
| 2.00 | NEW CAP REL COSTS-MVBLE EQUIP | 1,205,983 | 0 | 1,205,98 | 0.753007 | 0 | 2.0 |
| 3.00 | Total (sum of lines 1-2) | 1,601,557 | 0 | 1,601,55 | 1.000000 | 0 | 3.0 |
| | | ALLOCA | TION OF OTHER | CAPITAL | SUMMARY O | F CAPITAL | |
| | Cost Center Description | Taxes | Other | Total (sum of | Depreciation | Lease | |
| | | | Capital-Relate | cols. 5 | | | |
| | · · | | d Costs | through 7) | | | |
| | | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| 00 | PART III - RECONCILIATION OF CAPITAL CO | STS CENTERS | r | | | | |
| .00 | NEW CAP REL COSTS-BLDG & FIXT | 0 | 0 | 1 | 351,679 | 0 | 1.0 |
| 2.00 | NEW CAP REL COSTS-MVBLE EQUIP | 0 | 0 | (| 756,112 | 0 | 2.0 |
| 3.00 | Total (sum of lines 1-2) | 0 | 0 | (| 1,107,791 | 0, | 3.0 |
| | | | SU | JMMARY OF CAPI | TAL | | |
| | Cost Center Description | Interest | Insurance (see | | Other | Total (2) (sum | - National Association |
| | | | instructions) | instructions) | Capital-Relate | of cols. 9 | |
| | | | | | d Costs (see | through 14) | |
| | | 11.00 | 12 00 | 12.00 | instructions) | | |
| | PART III - RECONCILIATION OF CAPITAL CO | | 12.00 | 13.00 | 14.00 | 15.00 | |
| .00 | NEW CAP REL COSTS-BLDG & FIXT | The second secon | r | | J | | |
| .00 | NEW CAP REL COSTS-BLDG & FIXT | 0 | 0 | 1 | 0 | 351,679 | 1.0 |
| 3.00 | Total (sum of lines 1-2) | 0 | 0 | [| 0 | 756,112 | 2.0 |
| . 00 | Total (sum of lines 1-2) | į O | 1 0 | | 0 | 1,107,791 | 3.0 |

Provider CCN: 151310 | Period: From 01/01/2012 | Worksheet A-8 | From 01/01/2012 | Date /Time | Provider CCN: 151310 | Period: From 01/01/2013 | Pate /Time | Provider CCN: 151310 | Period: From 01/01/2013 | Pate /Time | Provider CCN: 151310 | Period: From 01/01/2013 | Pate /Time | Provider CCN: 151310 | Period: From 01/01/2013 | Pate /Time | Provider CCN: 151310 | Period: From 01/01/2013 | Pate /Time | Provider CCN: 151310 | Period: From 01/01/2013 | Pate /Time | Provider CCN: 151310 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/2013 | Period: From 01/01/20

| | | | | | To 12/31/2012 | Date/Time Pre | pared: |
|----------------|---|------------------------|---|---|---------------|----------------|----------------|
| | | | a mangan mingan ni sistempasi milat it unfahinanan aanut di apam ni apam milat mi | Expense Classification o To/From Which the Amount is | | 5/29/2013 8:0 | 08 am |
| | | | | | | | |
| | Cost Center Description | Basis/Code (2) 1.00 | Amount 2.00 | Cost Center 3.00 | | wkst. A-7 Ref. | |
| 1.00 | Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2) | | | NEW CAP REL COSTS-BLDG & FIXT | 1.00 | 5.00 0 | 1.00 |
| 2.00 | Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2) | В | -1,916 | NEW CAP REL COSTS-MVBLE EQUIP | 2.00 | 9 | 2.0 |
| 3.00 | Investment income - other (chapter 2) | | 0 | | 0.00 | 0 | 3.0 |
| 4.00 | Trade, quantity, and time discounts (chapter 8) | В | -3,408 | OTHER ADMINISTRATIVE AND | 5.01 | 0 | 4.0 |
| 5.00 | Refunds and rebates of expenses (chapter 8) | | 0 | GENERAL | 0.00 | 0 | 5.0 |
| 6.00 | Rental of provider space by suppliers (chapter 8) | | 0 | | 0.00 | 0 | 6.0 |
| 7.00 | Telephone services (pay stations excluded) (chapter 21) | | 0 | | 0.00 | 0 | 7.0 |
| 8.00 | Television and radio service (chapter 21) | В | -8,555 | OPERATION OF PLANT | 7.00 | 0 | 8.00 |
| 9.00 10.00 | Parking lot (chapter 21) Provider-based physician adjustment | A-8-2 | 0 -1,536,935 | | 0.00 | 0 | |
| 11.00 | | | 0 | | 0.00 | 0 | 11.00 |
| 12.00 | transactions (chapter 10) | A-8-1 | . 0 | | | 0 | 12.0 |
| 13.00 14.00 | Laundry and linen service Cafeteria-employees and guests | В | -229 954 | CAFETERIA | 0.00 | • | 13.0 |
| 15.00 | | | -229,934 | CAPETERIA | 11.00 0.00 | • | 14.00 15.00 |
| 16.00 | 1 | В | -1,405 | CENTRAL SERVICES & SUPPLY | 14.00 | 0 | 16.00 |
| 17.00 | | В | -113,299 | PHARMACY | 15.00 | 0 | 17.00 |
| L8.00 | Sale of medical records and abstracts | В | -16,360 | MEDICAL RECORDS & LIBRARY | 16.00 | 0 | 18.00 |
| 19.00 | Nursing school (tuition, fees, books, etc.) | | 0 | | 0.00 | 0 | 19.00 |
| 21.00 | Vending machines Income from imposition of interest, finance or penalty charges (chapter 21) | В | -409 0 | MAINTENANCE & REPAIRS | 6.00 | 0 | |
| 22.00 | Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments | | 0 | | 0.00 | 0 | 22.00 |
| 23.00 | Adjustment for respiratory therapy costs in excess of limitation (chapter 14) | A-8-3 | 0 | *** Cost Center Deleted *** | 65.00 | | 23.00 |
| 24.00 | Adjustment for physical therapy costs in excess of limitation (chapter 14) | A-8-3 | 0 | PHYSICAL THERAPY | 66.00 | | 24.00 |
| 25.00 | Utilization review - physicians' compensation (chapter 21) | | 0 | *** Cost Center Deleted *** | 114.00 | | 25.00 |
| 6.00 | Depreciation - NEW CAP REL COSTS-BLDG & FIXT | | | NEW CAP REL COSTS-BLDG & | 1.00 | 0 | 26.00 |
| 7.00 | Depreciation - NEW CAP REL COSTS-MVBLE EQUIP | | 0 1 | FIXT NEW CAP REL COSTS-MVBLE EQUIP | 2.00 | 0 | 27.00 |
| 8.00 9.00 | Non-physician Anesthetist | | | *** Cost Center Deleted *** | 19.00 | | 28.00 |
| 0.00 | Physicians' assistant Adjustment for occupational therapy costs in excess of | A-8-3 | 0 | *** Cost Center Deleted *** | 0.00 67.00 | o | 29.00 30.00 |
| 1.00 | limitation (chapter 14) Adjustment for speech pathology costs in excess of | A-8-3 | 0 | *** Cost Center Deleted *** | 68.00 | | 31.00 |
| 2.00 | limitation (chapter 14) CAH HIT Adjustment for | | 0 | | 0.00 | o | 32.00 |
| 3.00 | Depreciation and Interest DEVELOPMENT | А | -212,001 | OTHER ADMINISTRATIVE AND | 5.01 | | 33.00 |
| | | | | GENERAL | 3.01 | ٩ | 55.00 |

| ADJUST | MENTS TO EXPENSES | | | | | u of Form CMS- | |
|---------------|--|----------------|------------|--|------------------|----------------|--------|
| | | | | Provider CCN: 151310 | | Worksheet A-8 | • |
| | | | | Expense Classification on Worksheet To/From Which the Amount is to be Adjust Cost Center Line # 3.00 4.00 Cost Center Line # 3.00 4.00 A15 OTHER ADMINISTRATIVE AND GENERAL LABORATORY 60 OIS ANESTHESIOLOGY 53 A06 OTHER ADMINISTRATIVE AND GENERAL 691 OTHER ADMINISTRATIVE AND GENERAL 895 NEW CAP REL COSTS-BLDG & FIXT 950 EMPLOYEE BENEFITS 20 397 RADIOLOGY-DIAGNOSTIC 52 871 NEW CAP REL COSTS-MVBLE 52 | | Date/Time Pre | pared: |
| | | 1 | | Evponce Classification | | 5/29/2013 8:0 | 8 am |
| | | | | To/From Which the Amount i | on worksneet A | | ĺ |
| | | | | TOTALON WITCH THE ANOTHER | s to be Adjusted | | |
| | | | | | | | |
| | Cost Center Description | Basis/Code (2) | Amount | Cost Center | Line # | Wkst. A-7 Ref. | |
| 35 00 | The second secon | 1.00 | 2.00 | 3.00 | | 5.00 | |
| 35.00 | MISC REVENUE | В | -61,415 | OTHER ADMINISTRATIVE AND | 5.01 | 0 | 35.00 |
| 27 00 | | | | GENERAL | | | 33.00 |
| 37.00 | LAB FEES | В | -14,735 | LABORATORY | 60.00 | 0 | 37.00 |
| 38.00 | | | 0 | | 0.00 | _ | 38.00 |
| | ANESTHESIA | В | -1,164,015 | ANESTHESIOLOGY | 53.00 | | 40.00 |
| 42.00 | PHYSICIAN RECRUITING | A | -58,368 | OTHER ADMINISTRATIVE AND | 5.01 | 0 | |
| 43.00 | | | | | 3.02 | V | 42.00 |
| 43.00 | LOBBYING | A | -8,691 | OTHER ADMINISTRATIVE AND | 5.01 | 0 | 43.00 |
| 44.00 | BB 6B 8B 8B 8B 8B 8B 8B 8B 8B 8B 8B 8B 8B 8B | | | | | Ū | 73.00 |
| 44.00 | PROPERTY TAXES | A | -43,895 | NEW CAP REL COSTS-BLDG & | 1.00 | . 9 | 44.00 |
| 45.01 | ETTIPES STUDE | , | | | | 3 | 14.00 |
| | FITNESS CENTER | В | -1,950 | EMPLOYEE BENEFITS | 4.00 | 0 | 45.01 |
| i | MRI | В | -397 | RADIOLOGY-DIAGNOSTIC | 54.00 | ň | 45.02 |
| | HOSPITALIST | Α | | | 30.00 | 0 | 46.00 |
| 46.01 | EHR ASSET DEPRECIATION OFFSET | A | | | 2.00 | 0 | 46.01 |
| | | | | FOUTD | 2.00 | 9 | 70.03 |

EQUIP

-4,187,605

50.00

50.00 TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A, column 6, line 200.)

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151310

Period: | Worksheet A-8-2 | From 01/01/2012

| | | | | | | From 01/01/201 Fo 12/31/201 | 2 Date/Time Pr 5/29/2013 8: | |
|--------|-------------------|-------------------------------------|----------------------------------|---------------------------|-------------------------|--|--------------------------------|--------|
| | Wkst. A Line # | Cost Center/Physician Identifier | Total Remuneration | Professional Component | Provider Component | RCE Amount | Physician/Provider Component | |
| | | Tuester Tes | Remarier action | Component | Component | | Hours | 1 |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 6.00 | 7.00 | |
| 1.00 | | ELECTROCARDIOLOGY | 78,244 | | | | | 1.00 |
| 2.00 | | EMERGENCY | 807,069 | | | | | |
| 3.00 | 1 | EMERGENCY | 1,606,800 | | | | | |
| 4.00 | 0.00 | · = | 2,000,000 | 051,022 | | | | 1 |
| 5.00 | 0.00 | 1 | 0 | Č | , | | | 1 |
| 6.00 | 0.00 | 1 | Ŏ | | i i | | | 6.00 |
| 7.00 | 0.00 | · | 0 | | | | | |
| 8.00 | 0.00 | | | | | | | |
| 9.00 | 0.00 | | 0 | | | | _ | |
| 10.00 | 0.00 | | 0 | | | | 0 | 3.00 |
| 200.00 | 0.00 | | 2,492,113 | 1 526 025 | 055 170 | (| 0 | |
| | Wkst. A Line # | Cost Center/Physician | Unadjusted RCE | | | | 0 | |
| | WKSL. A LINE # | Identifier | Limit | | | Provider | Physician Cost | |
| | | Identifier | Limit | | Memberships & | Component | of Malpractice | 1 |
| | | | | Limit | Continuing Education | Share of col. | Insurance | |
| | 1.00 | 2.00 | 8.00 | 9.00 | 12.00 | 12 13.00 | 14.00 | |
| 1.00 | | ELECTROCARDIOLOGY | 0.00 | | | And the same of th | 14.00 | |
| 2.00 | | EMERGENCY | 1 | 1 | 1 | - | 1 | |
| 3.00 | | EMERGENCY | 0 | 1 | - | _ | 1 | |
| 4.00 | 0.00 | | 0 | _ | 1 | (| 0 | |
| 5.00 | 0.00 | | 0 | C | , | | 0 | 4.00 |
| 6.00 | 0.00 | | 0 | C | 0 | (| 0 | |
| 7.00 | 0.00 | | 0 | 1 | 0 | C | 0 | 6.00 |
| 8.00 | 0.00 | | 0 | 1 | 0 | C | 0 | 7.00 |
| 9.00 | 0.00 | | 0 | 0 | 0 | C | 0 | 8.00 |
| 10.00 | | | 0 | C | 0 | ļ |) 0 | 9.00 |
| 200.00 | 0.00 | | 0 | C | 0 | (| 1 | |
| 200.00 | tuliana A A dua 4 | | 0 | C | 0 | <u> </u> | 0 | 200.00 |
| | Wkst. A Line # | Cost Center/Physician | Provider | Adjusted RCE | RCE | Adjustment | | |
| | | Identifier | Component Share of col. 14 | Limit | Disallowance | | | |
| | 1.00 | 2.00 | 15.00 | 16.00 | 17.00 | 18.00 | 1 | ŀ |
| 1.00 | 69.00 | ELECTROCARDIOLOGY | 0 | 0 | 0 | | | 1.00 |
| 2.00 | 91.00 | EMERGENCY | 0 | 0 | 0 | 807,069 | | 2.00 |
| 3.00 | 91.00 | EMERGENCY | 0 | o o | ا م | 651,622 | | 3.00 |
| 4.00 | 0.00 | | 0 | ٥ | 0 | 031,022 | | 4.00 |
| 5.00 | 0.00 | | i o | آ آ | n | | | 5.00 |
| 6.00 | 0.00 | | l ő | 1 | n n | | | 6.00 |
| 7.00 | 0.00 | | 0 | 0 | , , | | | |
| 8.00 | 0.00 | | 1 0 | , o | | | } | 7.00 |
| 9.00 | 0.00 | | o o | 0 | | | | 8.00 |
| 10.00 | 0.00 | | 0 | l - | | 0 | | 9.00 |
| 200.00 | | | 0 | _ | 0 | 1 526 025 | | 10.00 |
| | ' | l | ı | ı | ή υ | 1,536,935 | 4 | 200.00 |

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151310

Period:
From 01/01/2012
To 12/31/2012
Date/Time Prepared:
5/29/2013 8:08 am

| | | | | | | 5/29/2013 8:0 | 8 am |
|----------------|--|---|---|--|----------------------|------------------------|--------|
| | | | CAPITAL REL | ATED COSTS | | | |
| | Cost Center Description | Net Expenses for Cost Allocation (from Wkst A col. 7) | NEW BLDG & FIXT | NEW MVBLE EQUIP | EMPLOYEE BENEFITS | Subtotal | |
| • | | 0 | 1.00 | 2.00 | 4.00 | 4A | |
| 1 00 | GENERAL SERVICE COST CENTERS | | ermenenenskappaniske dependenska erme – er j. e. i i j. j. j. j. j. j. j. j. j. j. j. j. j. | | | | |
| 1.00 | 00100 NEW CAP REL COSTS-BLDG & FIXT | 351,679 | 351,679 | | | | 1.00 |
| 2.00 | 00200 NEW CAP REL COSTS-MVBLE EQUIP | 756,112 | | 756,112 | | | 2.00 |
| 4.00 5.01 | 00400 EMPLOYEE BENEFITS | 564,151 | 8,289 | 7,203 | 579,643 | | 4.00 |
| 5.02 | 00561 OTHER ADMINISTRATIVE AND GENERAL 00560 BUSINESS OFFICE | 3,890,336 | 16,767 | 152,098 | 49,811 | 4,109,012 | 5.01 |
| 6.00 | 00600 MAINTENANCE & REPAIRS | 1,069,807 | 5,184 | 5,624 | 14,279 | 1,094,894 | |
| 7.00 | 00700 OPERATION OF PLANT | 672,636 | 0 | 179,348 | 11,431 | 863,415 | - |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | 518,920 | 71,237 | 0 | 0 | 590,157 | 7.00 |
| 9.00 | 00900 HOUSEKEEPING | 725 701 | 5 346 | 0 | 10.570 | 0 | 0.00 |
| 10.00 | 01000 DIETARY | 735,791 328,257 | 5,346 13,807 | 2 171 | 10,570 | 751,707 | 9.00 |
| 11.00 | 01100 CAFETERIA | 519,147 | 4,282 | 2,171 0 | 5,136 | 349,371 | |
| 13.00 | 01300 NURSING ADMINISTRATION | 202,435 | 1,336 | 0 | 11,720 5,367 | 535,149 | |
| 14.00 | 01400 CENTRAL SERVICES & SUPPLY | 1,088,877 | 14,576 | 669 | 1,591 | 209,138 | |
| 15.00 | 01500 PHARMACY | 2,761,351 | 8,762 | 906 | 24,042 | 1,105,713 2,795,061 | |
| 16.00 | 01600 MEDICAL RECORDS & LIBRARY | 700,972 | 11,379 | 508 | 12,303 | 725,162 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | 11,5/5 | 300 | 12,303 | 723,102 | 10.00 |
| 30.00 | 03000 ADULTS & PEDIATRICS | 2,080,951 | 30,251 | 9,285 | 61,576 | 2,182,063 | 30.00 |
| 43.00 | 04300 NURSERY | , , , | 0 | 0 | 01,3,0 | 2,102,003 | 43.00 |
| 44.00 | 04400 SKILLED NURSING FACILITY | 935,158 | 18,666 | 4,828 | 21,923 | 980,575 | |
| | ANCILLARY SERVICE COST CENTERS | | PHONE NAME OF THE PARTY OF THE | | | | 11100 |
| 50.00 | 05000 OPERATING ROOM | 1,434,561 | 22,892 | 115,094 | 25,014 | 1,597,561 | 50.00 |
| 51.00 | 05100 RECOVERY ROOM | 94,285 | 2,639 | 0 | 2,566 | 99,490 | 4 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | 0 | 0 | 0 | |
| 53.00 | 05300 ANESTHESIOLOGY | 48,435 | 476 | 0 | 26,495 | 75,406 | |
| 54.00 | 05400 RADIOLOGY-DIAGNOSTIC | 2,005,144 | 18,424 | 164,628 | 26,176 | 2,214,372 | 54.00 |
| 56.00 | 05600 RADIOISOTOPE | 218,911 | 0 | 626 | 3,144 | 222,681 | 56.00 |
| 60.00 63.00 | 06000 LABORATORY | 1,979,871 | 9,483 | 25,850 | 26,884 | 2,042,088 | 60.00 |
| | 06300 BLOOD STORING, PROCESSING & TRANS. 06600 PHYSICAL THERAPY | 109,058 | 0 | 0 | 0 | 109,058 | |
| 69.00 | 06900 ELECTROCARDIOLOGY | 1,306,820 | 2,339 | 7,115 | 31,691 | 1,347,965 | |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 746,913 | 2,859 | 12,515 | 19,189 | 781,476 | |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENT | 724,212 | 0 | 0 | 0 | 724,212 | |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 134,596 | 0 | 0 | 0 | 134,596 | |
| | OUTPATIENT SERVICE COST CENTERS | <u> </u> | | 0 | 0 | 0 | 73.00 |
| 90.00 | 09000 CLINIC | 179,571 | 2,709 | 10 465 | | 103 745 | |
| | 09001 SENIOR CARE | 269,346 | 5,722 | 10,465 | 0 | 192,745 | |
| | 09100 EMERGENCY | 2,111,606 | 9,152 | 8,915 | 4,871 30,002 | 279,939 | |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 2,111,000 | 3,132 | 0,913 | 30,002 | 2,159,675 0 | 91.00 |
| | OTHER REIMBURSABLE COST CENTERS | | VI.A | And the state of t | | | 92.00 |
| 101.00 | 10100 HOME HEALTH AGENCY | 1,364,081 | 5,318 | 0 | 30,207 | 1,399,606 | 101 00 |
| | SPECIAL PURPOSE COST CENTERS | | | | 30,201 | 1,333,000 | 101.00 |
| | 11600 HOSPICE | 779,684 | 0 | oſ | 13,704 | 793,388 | 116 00 |
| 118.00 | | 30,683,674 | 291,895 | 707,848 | 469,692 | 30,465,675 | |
| | NONREIMBURSABLE COST CENTERS | | | | | 30,103,073 | 110.00 |
| 190.00 | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 2,227 | 0 | 0 | 2.227 | 190.00 |
| 192.00 | 19200 PHYSICIANS' PRIVATE OFFICES | 5,009,216 | 43,905 | 48,264 | 104,377 | 5,205,762 | 192.00 |
| | 07950 FITNESS CENTER | 35 | 9,297 | 0 | 1 | | 194.00 |
| | 07951 MARKETING | 183,278 | 674 | 0 | 2,314 | 186,266 | |
| 104.02 | 07952 NEW DIRECTION 07953 RESPITE | 0 | 0 | O | 0 | | 194.02 |
| 104.03 | 07953 RESPITE 07954 WELL CHILD CLINIC | 0 | 0 | 0 | 0 | 0 | 194.03 |
| 200.00 | | 133,563 | 3,681 | 0 | 3,259 | 140,503 | 194.04 |
| 201.00 | | | | | | 0 | 200.00 |
| 202.00 | TOTAL (sum lines 118-201) | 36 000 766 | 0 | 0 | 0 | | 201.00 |
| 00 | 1.5 ME (54m 11065 110-201) | 36,009,766 | 351,679 | 756,112 | 579,643 | 36,009,766 | 202.00 |
| | | | | | | | |

66.0t 69.00

9(

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151310

| | | | | 1 | o 12/31/2012 | Date/Time Pre 5/29/2013 8:0 | |
|--------------|--|-----------------|---------|-----------------|---------------------------|--|------------------|
| | Cost Center Description | HOUSEKEEPING | DIETARY | CAFETERIA | NURSING ADMINISTRATION | CENTRAL SERVICES & SUPPLY | T an |
| | | 9.00 | 10.00 | 11.00 | 13.00 | 14.00 | - |
| | GENERAL SERVICE COST CENTERS | | | | | | |
| 1.00 | 00100 NEW CAP REL COSTS-BLDG & FIXT | | | | | The state of the s | 1.00 |
| 2.00 | 00200 NEW CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS | | | | | | 4.00 |
| 5.01 5.02 | 00561 OTHER ADMINISTRATIVE AND GENERAL | | | | | | 5.01 |
| 6.00 | 00560 BUSINESS OFFICE 00600 MAINTENANCE & REPAIRS | | | | | | 5.02 |
| 7.00 | 00700 OPERATION OF PLANT | | | | | | 6.00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | | | | | | 7.00 |
| 9.00 | 00900 HOUSEKEEPING | 022 047 | | | | | 8.00 |
| 10.00 | 01000 DIETARY | 922,947 | FF0 0C0 | | | | 9.00 |
| 11.00 | 01100 CAFETERIA | 52,044 | 558,860 | 676 473 | | | 10.00 |
| | 01300 NURSING ADMINISTRATION | 16,141 | 0 | 676,472 | 1 1 | | 11.00 |
| 14.00 | 01400 CENTRAL SERVICES & SUPPLY | 5,038 54,940 | 0 | 7,081 | | 1 462 216 | 13.00 |
| 15.00 | 01500 PHARMACY | 33,027 | 0 | 3,649 | i | 1,462,316 | |
| | 01600 MEDICAL RECORDS & LIBRARY | 42,892 | o | 32,115 | | 0 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | 42,032 | | 30,814 | 0 | 0 | 16.00 |
| 30.00 | 03000 ADULTS & PEDIATRICS | 114,026 | 179,853 | 87,783 | 98,846 | | 30.00 |
| 43.00 | 04300 NURSERY | 111,020 | 1/3,033 | 07,703 | | 0 | |
| 44.00 | 04400 SKILLED NURSING FACILITY | 70,357 | 247,306 | 52,561 | J • 1 | 0 | |
| | ANCILLARY SERVICE COST CENTERS | | 247,300 | 32,301 | <u> </u> | | 44.00 |
| 50.00 | 05000 OPERATING ROOM | 86,289 | 65,993 | 46,276 | 52,109 | 0 | 50.00 |
| 51.00 | 05100 RECOVERY ROOM | 9,949 | 0 | 3,540 | | 0 | |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | o | 0 | | 0 | 1 |
| 53.00 | 05300 ANESTHESIOLOGY | 1,795 | o | Ō | Ö | 0 | 1 |
| | 05400 RADIOLOGY-DIAGNOSTIC | 69,444 | 10,801 | 50,213 | 56,542 | 0 | 1 |
| | 05600 RADIOISOTOPE | 0 | 0 | 4,950 | | Õ | 56.00 |
| 60.00 | 06000 LABORATORY | 35,745 | 30 | 53,862 | o | 0 | 1 |
| 63.00 | 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | 0 | 0 | o | 0 | |
| | 06600 PHYSICAL THERAPY | 8,816 | 1,294 | 45,192 | 0 | 0 | 66.00 |
| 69.00 | 06900 ELECTROCARDIOLOGY | 10,778 | 5,957 | 35,402 | 0 | 0 | 69.00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | 1,462,316 | 71.00 |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 0 | 0 | 0 | 0 | |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | | 5,912 | 0 | 0 | 0 | 73.00 |
| 90.00 | OUTPATIENT SERVICE COST CENTERS 09000 CLINIC | | | | · - | | |
| | 09001 SENIOR CARE | 10,211 | 2,452 | 0 | ٠, | 0 | 90.00 |
| | 09100 EMERGENCY | 21,567 | 6,574 | 7,874 | | 0 | |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 34,497 | 25,693 | 50,069 | 56,380 | 0 | |
| 32.00 | OTHER REIMBURSABLE COST CENTERS | | | | | | 92.00 |
| 101.00 | 10100 HOME HEALTH AGENCY | 20,045 | 226 | | | | |
| | SPECIAL PURPOSE COST CENTERS | 20,043 | 226 | 0 | 0 | 0 | 101.00 |
| 116.00 | 11600 HOSPICE | 0 | 0 | 0 | 0 | | |
| 118.00 | | 697,601 | 552,091 | 511,381 | 9 | | 116.00 |
| | NONREIMBURSABLE COST CENTERS | 057,001 | 332,031 | 311,301 | 267,863 | 1,462,316 | 118.00 |
| 190.00 | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 8,396 | 0 | 0 | 0 | | 100 00 |
| 192.00 | 19200 PHYSICIANS' PRIVATE OFFICES | 165,494 | 6,769 | 1 54,795 | 0 | | 190.00 |
| 194.00 | 07950 FITNESS CENTER | 35,042 | 0,705 | 134,793 | 0 | | 192.00 |
| 194.01 | 07951 MARKETING | 2,540 | o | 3,071 | 0 | | 194.00 194.01 |
| 194.02 | 07952 NEW DIRECTION | 2,310 | ñ | 0,071 | 0 | | 194.01 |
| 194.03 | 07953 RESPITE | 0 | ő | n | ٥ | | 194.02 |
| 194.04 | 07954 WELL CHILD CLINIC | 13,874 | o | 7,225 | n | | 194.03 |
| 200.00 | - Too Too Tagas emeries | , , | ٦ | ., | 0 | | 200.00 |
| 201.00 | | 0 | o | o | o | | 201.00 |
| 202.00 | TOTAL (sum lines 118-201) | 922,947 | 558,860 | 676,472 | 267,863 | 1,462,316 | |
| | | | | , | 1 | , , | , |

| COST ALLOCAT | TION - GENERAL SERVICE COSTS | WABASH COUNTY | | CCN: 151310 | | eu of Form CMS-255 | |
|--------------|---|---------------|--|-------------|---|-------------------------|-------|
| | | | Flovider | | Period: From 01/01/2012 | Worksheet B Part I | |
| | | | | | To 12/31/2012 Date/Time Pr | | epar |
| | Cost Center Description | PHARMACY | MEDYCAL | C.U | | 5/29/2013 8: | 08 aı |
| | door content beach iperon | PHARMACY | MEDICAL RECORDS & | Subtotal | Intern & | Total | |
| | | | LIBRARY | | Residents Cost & Post | | |
| | | | LIBRARI | | Stepdown | | |
| | | | | | Adjustments | | |
| | | 15.00 | 16.00 | 24.00 | 25.00 | 26.00 | |
| GENER | AL SERVICE COST CENTERS | | | | and the same the same of the same the same and the same and the same and the same and the same and the same and | | _ |
| .00 00100 | NEW CAP REL COSTS-BLDG & FIXT | | | | I | | 1 |
| .00 00200 | NEW CAP REL COSTS-MVBLE EQUIP | 1 | | | | | 2 |
| .01 00460 | EMPLOYEE BENEFITS | | | | | | 4 |
| .02 00560 | OTHER ADMINISTRATIVE AND GENERAL | | i | | | | 5 |
| | BUSINESS OFFICE | | | | | | 5 |
| .00 00600 | MAINTENANCE & REPAIRS | | | | | | 6 |
| 00 00700 | OPERATION OF PLANT | | | | | | 7 |
| .00 00800 | LAUNDRY & LINEN SERVICE | | | | | | 8 |
| 0.00 01000 | HOUSEKEEPING | | | | | | g |
| | | | | | | | 10 |
| 01100 | CAFETERIA NURSING ADMINISTRATION | | - | | | | 11 |
| 00 01400 | CENTRAL SERVICES & SUPPLY | | | | 1 | | 13 |
| .00 01500 | CENTRAL SERVICES & SUPPLY | | | | | | 14 |
| 00 01600 | MEDICAL RECORDS & LIBRARY | 3,420,583 | i | | | | 15 |
| TAIDATT | MEDICAL RECORDS & LIBRARY | 0 | 1,006,827 | | <u> </u> | | 16 |
| 00 03000 | TENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS | | The state of the s | | | | |
| .00 04300 | WINDCEDA | 0 | 78,716 | 3,339,461 | 0 | 3,339,46 | 1 30 |
| | SKILLED NURSING FACILITY | 0 | 0 | (| 0 | | 0 43 |
| ANCTL | ARY SERVICE COST CENTERS | 0 | 17,014 | 1,671,668 | 0 | 1,671,668 | 1 |
| 00 05000 | OPERATING ROOM | | | | | | |
| 00 05100 | RECOVERY ROOM | 0 | 57,077 | 2,351,890 | 0 | 2,351,890 | 50 |
| .00 05200 | DELIVERY ROOM & LABOR ROOM | 0 | 5,359 | 158,262 | 0 | 158,262 | |
| 00 05300 | ANESTHESIOLOGY | 0 | 0 | C | | . (| - 1 |
| 00 05400 | RADIOLOGY PIAGNOSTIC | 0 | 11,017 | 104,992 | 2 0 | 104,992 | 2 53 |
| 00 05600 | RADIOISOTOPE | 0 | 183,136 | 3,112,237 | 0 | 3,112,237 | 7 54 |
| .00 06000 | I ARODATORY | 0 | 13,962 | 281,459 | 0 | 281,459 | 56 |
| .00 06300 | BLOOD STORING, PROCESSING & TRANS. | . 0 | 154,328 | 2,717,392 | T | 2,717,392 | 2 60 |
| .00 06600 | PHYSICAL THERAPY | 0 | 3,002 | 131,574 | 0 | 131,574 | |
| .00 06900 | ELECTROCARDIOLOGY | 0 | 34,893 | 1,695,651 | | 1,695,651 | 66 |
| .00 07100 | MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 37,270 | 1,030,744 | | 1,030,744 | |
| .00 07200 | IMPL. DEV. CHARGED TO PATIENTS | 0 | 58,256 | 2,374,372 | 0 | 2,374,372 | 71 |
| .00 07300 | DRUGS CHARGED TO PATIENTS | 3 430 503 | 10,827 | 169,507 | T . | 169,507 | 7 72 |
| OUTPAT | IENT SERVICE COST CENTERS | 3,420,583 | 241,531 | 3,668,026 | 0 | 3,668,026 | 73 |
| .00 09000 | CLINIC | | | | | | 1 |
| | SENIOR CARE | 0 | 10,521 | 269,343 | | 269,343 | 90 |
| 00 09100 | EMERGENCY | 0 | 6,564 | 411,922 | | 411,922 | 90 |
| .00 09200 | OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 83,354 | 2,812,885 | 0 | 2,812,885 | |
| OTHER | REIMBURSABLE COST CENTERS | | | | 0 | | 92 |
| 1.00 10100 H | HOME HEALTH AGENCY | · | | | API- | | |
| SPECTAL | L PURPOSE COST CENTERS | 0 | 0 | 1,706,865 | 0 | 1,706,865 | 101 |
| 6.00 11600 H | HOSPICE | | | | , <u>.</u> | | 1 |
| | SUBTOTALS (SUM OF LINES 1-117) | 7 420 502 | 0 | 935,359 | -1 | 935,359 | 116 |
| | MBURSABLE COST CENTERS | 3,420,583 | 1,006,827 | 28,943,609 | 0 | 28,943,609 | 118 |
| 0.00 19000 a | GIFT, FLOWER, COFFEE SHOP & CANTEEN | | | | | | 1 |
| .00 19200 F | PHYSICIANS' PRIVATE OFFICES | 0 | 0 | 26,214 | - 1 | 26,214 | 190 |
| .00 07950 F | FITNESS CENTER | 0 | 0 | 6,505,006 | | 6,505,006 | 192 |
| .01 07951 M | MARKETING | 0 | 0 | 109,450 | 0 | 109,450 | 194 |
| .02 07952 N | NEW DIRECTION | .0 | 0 | 220,498 | o | 220,498 | |
| .03 07953 R | RESPITE | 0 | 0 | 0 | 0 | | 194. |
| .04 07954 | ELL CHILD CLINIC | 0 | 0 | 0 | 0 | | 194. |
| 0.00 | cross Foot Adjustments | 0 | 0 | 204,989 | 0 | 204,989 | |
| | legative Cost Centers | | | 0 | o | | 200. |
| | OTAL (sum lines 118-201) | 0 | 0 | 0 | 0 | | 201. |
| | O'UE (200 11162 TT0-50T) | 3,420,583 | 1,006,827 | 36,009,766 | ol | 36,009,766 | |

| | Financial Systems ALLOCATION STATISTICS | WABASH COUNTY HOSPITAL | | | of Form C | |
|-------|---|--|-------------|----------------------------------|-----------|-----------|
| 2001 | ACCOCATION STATISTICS | Provider | CCN: 151310 | Period: | Worksheet | Non-CMS W |
| | | | | From 01/01/2012 To 12/31/2012 | Date/Time | Prenared. |
| | | | | -1, 52, 2012 | 5/29/2013 | 8:08 am |
| | Cost Center Description | | Statistics | Statistics I | | |
| | | | Code | | • | 1 |
| | | | 1.00 | 2.0 | 00 | |
| 1 00 | GENERAL SERVICE COST CENTERS | The state of the s | | | | |
| 1.00 | NEW CAP REL COSTS-BLDG & FIXT | | 3 | SQUARE F | EET | 1.00 |
| 2.00 | NEW CAP REL COSTS-MVBLE EQUIP | | 4 | DOLLAR VA | LUE | 2.00 |
| 4.00 | EMPLOYEE BENEFITS | | S | GROSS SALARIES | | 4.00 |
| 5.01 | OTHER ADMINISTRATIVE AND GENERAL | | -5 | ACCUM. COST | | 5.01 |
| 5.02 | BUSINESS OFFICE | | 5 | ACCUM, COST | | 5.02 |
| 6.00 | MAINTENANCE & REPAIRS | | 3 | | EET | 6.00 |
| 7.00 | OPERATION OF PLANT | | 3 | ' | EET | 7.00 |
| 8.00 | LAUNDRY & LINEN SERVICE | | 8 | 1 * | AUNDRY | 8.00 |
| 9.00 | HOUSEKEEPING | | 3 | _ | EET | 9.00 |
| 10.00 | DIETARY | | 10 | | VED | 10.00 |
| | CAFETERIA | | 11 | HOURS | VLD | 1 |
| | NURSING ADMINISTRATION | | 13 | 1 | NG HRS | 11.00 |
| 14.00 | CENTRAL SERVICES & SUPPLY | | 14 | 1 | | |
| 15.00 | PHARMACY | | 15 | 1.24 | UIS. | 14.00 |
| 16.00 | MEDICAL RECORDS & LIBRARY | | 16 | | UIS. | 15.00 |
| | | | 10 | GROSS REV | | 16.00 |

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151310

Period: Worksheet B From 01/01/2012 Part II
Date/Time Prepared:

12/31/2012

5/29/2013 8:08 am CAPITAL RELATED COSTS Cost Center Description Directly NEW BLDG & NEW MVBLE Subtotal **EMPLOYEE** Assigned New FIXT **BENEFITS** Capital Related Costs 0 1.00 2.00 2A 4.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS 8,289 7,203 15,492 15,492 4.00 5.01 00561 OTHER ADMINISTRATIVE AND GENERAL 16,767 152,098 168,865 1,331 5.01 5.02 00560 BUSINESS OFFICE 5,184 5.624 10,808 382 5.02 6.00 00600 MAINTENANCE & REPAIRS 179,348 179,348 305 6.00 7.00 00700 OPERATION OF PLANT 71,237 0 71,237 0 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 0 0 8.00 9.00 00900 HOUSEKEEPING 5.346 5.346 282 9.00 10.00 01000 DIETARY 0 13,807 2,171 15,978 137 10.00 11.00 01100 CAFETERIA 4,282 4,282 313 11.00 01300 NURSING ADMINISTRATION 13.00 0 1.336 0 1,336 143 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 14,576 669 15,245 43 14.00 15.00 01500 PHARMACY 8,762 906 9,668 642 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 11,379 508 11,887 329 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 30,251 9,285 39,536 1,645 30.00 04300 NURSERY 43.00 0 0 43.00 44.00 04400 SKILLED NURSING FACILITY 0 18,666 4,828 23,494 586 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 22,892 115,094 137,986 50.00 668 51.00 05100 RECOVERY ROOM 0 2,639 2,639 69 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 n n 52.00 53.00 05300 ANESTHESIOLOGY 0 476 476 708 53.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 18,424 164,628 183,052 699 54.00 56.00 05600 RADIOISOTOPE 0 626 626 84 56.00 06000 LABORATORY 60.00 0 9,483 25,850 35,333 718 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 n 63.00 66.00 06600 PHYSICAL THERAPY 0 2,339 7,115 9.454 847 66.00 69.00 06900 ELECTROCARDIOLOGY 0 2.859 12,515 15,374 513 69.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 0 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 2,709 10,465 13,174 n 90.00 90.01 09001 SENIOR CARE 0 5,722 5,722 130 90.01 91.00 09100 EMERGENCY 0 9.152 8,915 18,067 802 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 5,318 0 5,318 807 101.00 SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPICE 0 366 116.00 SUBTOTALS (SUM OF LINES 1-117) 0 291,895 707,848 999,743 12,549 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 2,227 2,227 0 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 43,905 48,264 92,169 2,794 192.00 194.00 07950 FITNESS CENTER 0 9,297 0 9,297 0 194.00 194.01 07951 MARKETING 0 674 0 674 62 194.01 194.02 07952 NEW DIRECTION 0 0 0 0 0 194.02 194.03 07953 RESPITE 0 0 194.03 194.04 07954 WELL CHILD CLINIC 0 3,681 0 3,681 87 194.04 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118-201)

351,679

756,112

1,107,791

15,492 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151310 | Period: | Worksheet B | From 01/01/2012 | To 12/31/2012 | Date/Time Prepared: | 5/30/2013 8:08 am

| | | | | | 1 | 0 12/31/2012 | Date/Time Pre 5/29/2013 8:0 | |
|----|--------|--|----------------|--|---|--|-----------------------------|--------|
| | | Cost Center Description | OTHER | BUSINESS | MAINTENANCE & | OPERATION OF | LAUNDRY & | |
| | | · | ADMINISTRATIVE | OFFICE | REPAIRS | PLANT | LINEN SERVICE | |
| | | | AND GENERAL | | | | | |
| | | | 5.01 | 5.02 | 6.00 | 7.00 | 8.00 | |
| | | GENERAL SERVICE COST CENTERS | | . A. C. COMPANIAN SINGS OF A STATE OF THE ST | 4 | processors to the second contract of the seco | | |
| | 1.00 | 00100 NEW CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| | 2.00 | 00200 NEW CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| | 4.00 | 00400 EMPLOYEE BENEFITS | | | | | | 4.00 |
| | 5.01 | 00561 OTHER ADMINISTRATIVE AND GENERAL | 170,196 | | | | | 5.01 |
| | 5.02 | 00560 BUSINESS OFFICE | 5,841 | 17,031 | | | | 5.02 |
| | 6.00 | 00600 MAINTENANCE & REPAIRS | 4,606 | 670 | 184,929 | | | 6.00 |
| | 7.00 | 00700 OPERATION OF PLANT | 3,148 | 408 | 40,979 | 115,772 | | 7.00 |
| | 8.00 | 00800 LAUNDRY & LINEN SERVICE | 0 | 0 | 0 | 0 | 0 | 8.00 |
| | 9.00 | 00900 HOUSEKEEPING | 4,010 | 519 | 3,076 | 2,474 | 0 | 9.00 |
| | 10.00 | 01000 DIETARY | 1,864 | 242 | 7,944 | 6,389 | 0 | 10.00 |
| | | | 2,855 | 370 | 2,464 | 1,981 | 0 | 11.00 |
| | 13.00 | 01300 NURSING ADMINISTRATION | 1,116 | 145 | 769 | 618 | 0 | 13.00 |
| | | 01400 CENTRAL SERVICES & SUPPLY | 5,899 | 764 | 8,386 | 6,744 | 0 | 14.00 |
| | 15.00 | 01500 PHARMACY | 14,912 | 1,930 | 5,041 | 4,054 | 0 | 15.00 |
| | 16.00 | 01600 MEDICAL RECORDS & LIBRARY | 3,869 | 501 | 6,547 | 5,265 | 0 | 16.00 |
| | | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | 1 |
| | 30.00 | 03000 ADULTS & PEDIATRICS | 11,641 | 1,506 | 17,404 | 13,998 | ō | 30.00 |
| | | 04300 NURSERY | 0 | 0 | 0 | 0 | 0 | 43.00 |
| | 44.00 | 04400 SKILLED NURSING FACILITY | 5,231 | 680 | 10,739 | 8,637 | 0 | 44.00 |
| | | ANCILLARY SERVICE COST CENTERS | | | *************************************** | | | |
| | | 05000 OPERATING ROOM | 8,523 | 1,151 | 13,170 | 10,593 | 0 | 50.00 |
| | | 05100 RECOVERY ROOM | 531 | 69 | 1,519 | 1,221 | 0 | 51.00 |
| | | 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | 0 | 0 | 0 | 52.00 |
| | | 05300 ANESTHESIOLOGY | 402 | 52 | 274 | 220 | 0 | 53.00 |
| | | 05400 RADIOLOGY-DIAGNOSTIC | 11,814 | 1,598 | 10,599 | 8,525 | 0 | 54.00 |
| | | 05600 RADIOISOTOPE | 1,188 | 154 | 0 | 0 | 0 | 56.00 |
| | 60.00 | 06000 LABORATORY | 10,895 | 1,422 | 5,456 | 4,388 | 0 | 60.00 |
| | 63.00 | 06300 BLOOD STORING, PROCESSING & TRANS. | 582 | 75 | 0 | 0 | 0 | 63.00 |
| | | 06600 PHYSICAL THERAPY | 7,191 | 935 | 1,346 | 1,082 | 0 | 66.00 |
| | 69.00 | 06900 ELECTROCARDIOLOGY | 4,169 | 545 | 1,645 | 1,323 | 0 | 69.00 |
| | 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 3,864 | 500 | 0 | o | 0 | 71.00 |
| ١. | 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENT | 718 | 93 | 0 | 0 | 0 | 72.00 |
| , | 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | 0 | o | 0 | 73.00 |
| | | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| | | 09000 CLINIC | 1,028 | 137 | 1,559 | 1,254 | 0 | 90.00 |
| | | 09001 SENIOR CARE | 1,493 | 193 | 3,292 | 2,647 | 0 | 90.01 |
| | 91.00 | 09100 EMERGENCY | 11,522 | 857 | 5,265 | 4,235 | 0 | 91.00 |
| | 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | _ | | | | 92.00 |
| | 404.00 | OTHER REIMBURSABLE COST CENTERS | | | | | | |
| | 101.00 | 10100 HOME HEALTH AGENCY | 7,467 | 967 | 3,060 | 2,461 | 0 | 101.00 |
| | 116 00 | SPECIAL PURPOSE COST CENTERS | | | | | | |
| | | 11600 HOSPICE | 4,233 | 548 | - | 0 | 0 | 116.00 |
| | 118.00 | | 140,612 | 17,031 | 150,534 | 88,109 | 0 | 118.00 |
| | 100 00 | NONREIMBURSABLE COST CENTERS | | | | | | |
| | 102.00 | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 12 | 0 | _,,_ | 1,031 | 0 | 190.00 |
| | 104.00 | 19200 PHYSICIANS' PRIVATE OFFICES | 27,778 | 0 | 25,259 | 20,315 | | 192.00 |
| | 104.00 | 07950 FITNESS CENTER | 50 | 0 | ,,,,,, | 4,302 | | 194.00 |
| | | 07951 MARKETING | 994 | 0 | 388 | 312 | | 194.01 |
| | 104.02 | 07952 NEW DIRECTION 07953 RESPITE | 0 | 0 | 0 | 0 | | 194.02 |
| | 104.03 | 070E4 VELL CUTED CLITERS | 0 | 0 | 0 | 0 | | 194.03 |
| | 200 00 | 07954 WELL CHILD CLINIC | 750 | 0 | 2,118 | 1,703 | | 194.04 |
| | 200.00 | , | | İ | | | | 200.00 |
| | 201.00 | | 0 | 0 | 0 | 0 | | 201.00 |
| | 202.00 | TOTAL (sum lines 118-201) | 170,196 | 17,031 | 184,929 | 115,772 | 0 | 202.00 |
| | | | | | | | | |

| ALLOCA | NTION OF CAPITAL RELATED COSTS | | Provider | | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part II Date/Time Pre 5/29/2013 8:0 | |
|--------------|---|--------------|----------|-----------------------|---|--|--------|
| | Cost Center Description | HOUSEKEEPING | DIETARY | CAFETERIA | NURSING ADMINISTRATION | CENTRAL SERVICES & SUPPLY | |
| | | 9.00 | 10.00 | 11.00 | 13.00 | 14.00 | |
| 1 00 | GENERAL SERVICE COST CENTERS | | | | T | | |
| 1.00 | 00100 NEW CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 2.00 | 00200 NEW CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| 4.00 5.01 | 00400 EMPLOYEE BENEFITS | | | | | | 4.00 |
| | 00561 OTHER ADMINISTRATIVE AND GENERAL | | | | | | 5.01 |
| 5.02 6.00 | 00560 BUSINESS OFFICE | | | | | | 5.02 |
| 7.00 | 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT | | | | | | 6.00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | | | | | | 7.00 |
| 9.00 | 00900 HOUSEKEEPING | 15 707 | | | | | 8.00 |
| | 01000 DIETARY | 15,707 | 72 440 | | | | 9.00 |
| | 01100 CAFETERIA | 886 | 33,440 | 13 54 | | | 10.00 |
| | 01300 NURSING ADMINISTRATION | 275 | 0 | 12,54 | | | 11.00 |
| | 01400 CENTRAL SERVICES & SUPPLY | 86 935 | 0 | 13: | | 30 004 | 13.00 |
| | 01500 PHARMACY | 562 | 0 | 6 ₆ 59. | | 38,084 | |
| | 01600 MEDICAL RECORDS & LIBRARY | 730 | 0 | 57: | | 0 | 15.00 |
| 10.00 | INPATIENT ROUTINE SERVICE COST CENTERS | 7 30 | U | 37. | r | V | 16.00 |
| 30.00 | 03000 ADULTS & PEDIATRICS | 1,941 | 10,762 | 1,62 | 7 1,603 | | 30.00 |
| | 04300 NURSERY | 0 | 10,702 | • | 0 1,003 | 0 | 30.00 |
| | 04400 SKILLED NURSING FACILITY | 1,197 | 14,798 | 97 | 1 | 0 | 1 |
| | ANCILLARY SERVICE COST CENTERS | <u> </u> | 14,730 | 31. | <u>+</u> | | 44.00 |
| 50.00 | 05000 OPERATING ROOM | 1,468 | 3,949 | 85 | 845 | 0 | 50.00 |
| | 05100 RECOVERY ROOM | 169 | 0,519 | 6 | | 0 | 51.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | ő | | 0 | 0 | 52.00 |
| 53.00 | 05300 ANESTHESIOLOGY | 31 | Ö | | o o | 0 | 53.00 |
| | 05400 RADIOLOGY-DIAGNOSTIC | 1,182 | 646 | 93: | -1 | 0 | 54.00 |
| | 05600 RADIOISOTOPE | 0 | 0 | 9: | 1 | 0 | 56.00 |
| | 06000 LABORATORY | 608 | 2 | 99 | | ő | 60.00 |
| 63.00 | 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | 0 | | ol ol | ő | 63.00 |
| 66.00 | 06600 PHYSICAL THERAPY | 150 | 77 | 83 | | ŏ | 66.00 |
| | 06900 ELECTROCARDIOLOGY | 183 | 356 | 65 | | ő | 69.00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | ol ol | 38,084 | |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | o | (| ol ol | 0 | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 354 | (| o o | 0 | 73.00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| | 09000 CLINIC | 174 | 147 | (| 0 | 0 | 90.00 |
| | 09001 SENIOR CARE | 367 | 393 | 140 | 5 0 | 0 | 90.01 |
| | 09100 EMERGENCY | 587 | 1,537 | 928 | 914 | 0 | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92.00 |
| 101 00 | OTHER REIMBURSABLE COST CENTERS | ., | | | | | |
| 101.00 | 10100 HOME HEALTH AGENCY | 341 | 14 | | 0 | 0 | 101.00 |
| 116 00 | SPECIAL PURPOSE COST CENTERS | T - | | | · · · · · · · · · · · · · · · · · · · | | |
| | 11600 HOSPICE | 0 | 0 | | 0 | | 116.00 |
| 118.00 | | 11,872 | 33,035 | 9,479 | 4,344 | 38,084 | 118.00 |
| 100.00 | NONREIMBURSABLE COST CENTERS | 1 = | | | | | |
| 102.00 | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES | 143 | 0 | | 0 | | 190.00 |
| 194 00 | 07950 FITNESS CENTER | 2,817 | 405 | 2,870 | 0 | | 192.00 |
| | 07951 MARKETING | 596 | 0 | (| 9 | | 194.00 |
| | 07952 NEW DIRECTION | 43 | 0 | 57 | | | 194.01 |
| 194 03 | 07953 RESPITE | 0 | 0 | (| 1 | | 194.02 |
| 194 04 | 07954 WELL CHILD CLINIC | 236 | 0 | 13. | 1 | | 194.03 |
| 200.00 | Cross Foot Adjustments | 236 | Ч | 134 | • | | 194.04 |
| 201.00 | | 0 | م | , | | | 200.00 |
| 202.00 | | 15,707 | 33,440 | 10 54/ | 4 344 | | 201.00 |
| | , (| 13,707 | 33,440 | 12,540 | 4,344 | 38,084 | 202.00 |

0

0

0

0

0

0

0

37,404

174,407

19,594

2,530

8,709

1,107,791

0

0

0

0

0

0

0

0

0

0

174,407 192.00

19,594 194.00

2,530 194.01

8,709 194.04

1,107,791 202.00

0 194.02

0 194.03

0 200.00

0 201.00

0

0

0

0

0

29,699

194.00 07950 FITNESS CENTER

194.02 07952 NEW DIRECTION

194.04 07954 WELL CHILD CLINIC

Cross Foot Adjustments

TOTAL (sum lines 118-201)

Negative Cost Centers

194.01 07951 MARKETING

194.03 07953 RESPITE

200.00

201.00

| | | | | From 01/01/2012 To 12/31/2012 | worksileet B- | |
|---|--|--|--|--|------------------------------|------------------|
| | CAPTTAL REI | LATED COSTS | | To 12/31/2012 | Date/Time Pr 5/29/2013 8: | epared: 08 am |
| Cost Center Description | NEW BLDG & FIXT (SQUARE | NEW MVBLE EQUIP (DOLLAR | EMPLOYEE BENEFITS (GROSS | Reconciliation | OTHER ADMINISTRATIV | |
| | FEET) | VALUE) | SALARIES) | | AND GENERAL | |
| GENERAL SERVICE COST CENTERS | 1.00 | 2.00 | 4.00 | 5A.01 | (ACCUM. COST) | |
| 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT | | | | JA.01 | 5.01 | |
| 2.00 UU2UU NEW CAP REL COSTS-MURIE FOLLTO | 126,309 | | The second secon | | | 1 00 |
| 4.00 UU4UU EMPLOYEE BENEFTTS | 2 | 1,298,970 | | | | 1.00 |
| 5.01 00561 OTHER ADMINISTRATIVE AND GENER | 2,977 | 12,374 | |) | | 4.00 |
| 3.02 OOSOO BUSINESS OFFICE | 6,022 1,862 | 261,298 | _,, | | 31,900,754 | |
| 6.00 00600 MAINTENANCE & REPAIRS | 0 | 9,662 | , | 1 0 | 1,094,894 | |
| 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE | 25,585 | 308,112 0 | , | 9 | 863,415 | |
| | 25,383 | 0 | C | 0 | 590,157 | 7.00 |
| 9.00 00900 HOUSEKEEPING 10.00 01000 DIETARY | 1,920 | 0 | 288,206 | 0 | C | |
| 11.00 01100 CAFETERIA | 4,959 | 3,729 | 140,029 | | 751,707 | 1 + |
| 13.00 01300 NURSING ADMINISTRATION | 1,538 | 0 | 319,553 | | 349,371 | |
| 14.00 01400 CENTRAL SERVICES & SUPPLY | 480 | 0 | 146,327 | 0 | 535,149 | 0 |
| 13.00 01500 PHARMACY | 5,235 | 1,150 | 43,369 | o o | 209,138 1,105,713 | |
| 16.00 01600 MEDICAL RECORDS & LIBRARY | 3,147 | 1,556 | 655,535 | ŏ | 2,795,061 | 14.00 |
| INPATIENT ROUTINE SERVICE COST STATE | 4,087 | 873 | 335,469 | | 725,162 | 16.00 |
| 30.00 U3000 ADULTS & PENTATOTOS | The state of the s | and the same of th | | And the second s | | 10.00 |
| 43.00 04300 NURSERY | 10,865 | 15,951 | 1,678,963 | 0 | 2,182,063 | 30.00 |
| 44.00 04400 SKILLED NURSING FACILITY | 6,704 | 9 205 | 0 | 0 | 0 | |
| ANCILLARY SERVICE COST CENTERS | 0,704 | 8,295 | 597,765 | 0 | 980,575 | |
| 50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM | 8,222 | 197,726 | 682,037 | | | |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 948 | 237,720 | 69,967 | 0 | 1,597,561 | |
| 53.00 05300 ANESTHESIOLOGY | o | ŏ | 05,507 | 0 | 99,490 | |
| 54.00 05400 RADIOLOGY-DIAGNOSTIC | 171 | o | 722,440 | 0 | 75 405 | |
| 56.00 05600 RADIOISOTOPE | 6,617 | 282,825 | 713,726 | o o | 75,406 | 53.00 |
| 60.00 06000 LABORATORY | 0 | 1,076 | 85,732 | 0 | 2,214,372 222,681 | 54.00 |
| 63.00 06300 BLOOD STORING PROCESSING & TO | 3,406 | 44,410 | 733,035 | 0 | 2,042,088 | 50.00 |
| OUT OUT OF THERAPY | ١ | 0 | 0 | 0 | 109,058 | 63.00 |
| 69.00 06900 ELECTROCARDIOLOGY | 840 1,027 | 12,223 | 864,100 | 0 | 1,347,965 | 66.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT | IENTS 1,027 | 21,501 | 523,228 | 0 | 781,476 | 69.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO DATTENT | Ö | 0 | 0 | 0 | 724,212 | 71.00 |
| CHARGED III PATTENTE | | o | 0 | 0 | 134,596 | 72.00 |
| 90.00 09000 CLINIC | | <u>_</u> | | 0 | 0 | 73.00 |
| 90.01 09001 SENIOR CARE | 973 | 17,979 | 0 | 0 | | |
| 91.00 09100 EMERGENCY | 2,055 | 0 | 132,826 | o o | 192,745 | 90.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT F | 3,287 | 15,315 | 818,040 | 0 | | 90.01 |
| | ART | | | Ĭ | 2,139,673 | 91.00 92.00 |
| 101.00 10100 HOME HEALTH AGENCY | 1,910 | | | | | 32.00 |
| SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPICE | 1,910 | 0 | 823,646 | 0 | 1,399,606 1 | 01.00 |
| 118.00 SUBTOTALS (SUM OF LINES 1 117) | 0 | 0 | 272 674 | | | |
| | 104,837 | 1,216,055 | 373,674 12,806,860 | 0 | 793,388 1 | 16.00 |
| NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANT | | 2,010,033 | 12,800,860 | -4,109,012 | 26,356,663 | 18.00 |
| 192.00 19200 PHYSICIANS' PRIVATE OFFICES | EEN 800 | 0 | | | | |
| 434.UUIU/93UIFTTNESS CENTER | 15,769 | 82,915 | 2,845,903 | 0 | 2,227 1 | 90.00 |
| 194.01/07951 MARKETTNG | 3,339 | 0 | 24 | 0 | 5,205,762 1 | 92.00 |
| 194.02/07952/NEW DIRECTION | 242 | 0 | 63,093 | 0 | 9,333 1 186,266 1 | 94.00 |
| 194.03(07953) RESPITE | 0 | 0 | o | ő | | 94.01 94.02 |
| 194.04 07954 WELL CHILD CLINIC | 1,322 | 0 | 0 | o | | 94.02 |
| 200.00 Cross Foot Adjustments | 1,322 | O | 88,849 | o | 140,503 | 94.04 |
| The sacrace cost centers | | | | | | 00.00 |
| Cost to be allocated (per wkst. part I) | 351,679 | 756,112 | 570 643 | | 20 | 01.00 |
| 203.00 Unit cost multiplion (utage | | , 50, 112 | 579,643 | | 4,109,012 20 | 02.00 |
| Unit cost multiplier (wkst. B, Pa Cost to be allocated (per wkst. B | art I) 2.784275 | 0.582086 | 0.036675 | | İ | |
| Part II) | 1 | | 15,492 | | 0.128806 20 | 3.00 |
| Unit cost multiplier (Wkst. B, Pa | urt | | | | 170,196 20 | 04.00 |
| II) | | | 0.000980 | | 0.005335 20 | NE 00 |
| | | | | | | |

COST ALLOCATION - STATISTICAL BASIS

| | | | | Т | o 12/31/2012 | Date/Time Pre 5/29/2013 8:0 | |
|-------|--|-------------------------------------|--|--|--|----------------------------------|--------|
| | Cost Center Description | BUSINESS OFFICE (ACCUM. COST) | MAINTENANCE & REPAIRS (SQUARE FEET) | OPERATION OF PLANT (SQUARE FEET) | LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY) | HOUSEKEEPING (SQUARE FEET) | |
| | | 5.02 | 6.00 | 7.00 | 8.00 | 9.00 | |
| | GENERAL SERVICE COST CENTERS | | | Part and the state of the state | | | |
| 1.00 | 00100 NEW CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 2.00 | 00200 NEW CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS | | | · · | | | 4.00 |
| 5.01 | 00561 OTHER ADMINISTRATIVE AND GENERAL | | | | | | 5.01 |
| 5.02 | 00560 BUSINESS OFFICE | 24,654,255 | | | | | 5.02 |
| 6.00 | 00600 MAINTENANCE & REPAIRS | 970,205 | 115,448 | | | | 6.00 |
| 7.00 | 00700 OPERATION OF PLANT | 590,157 | 25,585 | 89,863 | | | 7.00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | o | 0 | | 155,759 | | 8.00 |
| 9.00 | 00900 HOUSEKEEPING | 751,785 | 1,920 | 1,920 | | 87,943 | |
| 10.00 | 01000 DIETARY | 350,700 | 4,959 | | | 4,959 | |
| 11.00 | l i | 535,235 | 1,538 | | | 1,538 | |
| 13.00 | I I | 209,177 | 480 | | | 480 | 1 |
| 14.00 | | 1,106,123 | 5,235 | | l i | 5,235 | |
| 15.00 | | 2,795,777 | 3,147 | | i i | 3,233 | |
| 16.00 | | 725,556 | 4,087 | | | | 1 |
| 10.00 | INPATIENT ROUTINE SERVICE COST CENTERS | _ /23,330 | 4,007 | 4,007 | | 4,087 | 16.00 |
| 30.00 | | 2 170 735 | 10.865 | 10 005 | 36 466 | 10.005 | |
| 43.00 | | 2,179,735 | 10,803 | l ' . | · . [| 10,865 | 1 |
| | | 003 610 | 6 704 | 0 | 1 | 0 | |
| 44.00 | P. COLOR TO THE PROPERTY OF TH | 983,610 | 6,704 | 6,704 | 42,346 | 6,704 | 44.00 |
| FO 00 | ANCILLARY SERVICE COST CENTERS | | | r . | | | |
| 50.00 | | 1,666,224 | 8,222 | l ' | | 8,222 | |
| 51.00 | | 99,509 | 948 | | 0 | 948 | 51.00 |
| 52.00 | | 0 | 0 | _ | 0 | 0 | 52.00 |
| 53.00 | | 75,602 | 171 | 171 | 0 | 171 | 53.00 |
| 54.00 | | 2,312,516 | 6,617 | 6,617 | 14,116 | 6,617 | 54.00 |
| 56.00 | 1 | 223,077 | 0 | 0 | 0 | 0 | 56.00 |
| 60.00 | | 2,057,668 | 3,406 | 3,406 | 0 | 3,406 | 60.00 |
| 63.00 | | 109,058 | 0 | 0 | 0 | 0 | 63.00 |
| 66.00 | 06600 PHYSICAL THERAPY | 1,352,432 | 840 | 840 | 0 | 840 | 66.00 |
| 69.00 | | 789,065 | 1,027 | 1,027 | o | 1,027 | |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 724,212 | . 0 | | o | 0 | |
| 72.00 | | 134,596 | 0 | | · · · · · · · · · · · · · · · · · · · | Ö | |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | | ő | - |
| | OUTPATIENT SERVICE COST CENTERS | | | · | <u> </u> | | 73.00 |
| 90.00 | | 198,972 | 973 | 973 | 0 | 973 | 90.00 |
| 90.01 | | 279,975 | 2,055 | | - | | |
| 91.00 | 1 | 1,239,970 | | | | 2,055 | 1 |
| 92.00 | 1 | 1,239,970 | 3,287 | 3,287 | 5,785 | 3,287 | 1 |
| 32.00 | OTHER REIMBURSABLE COST CENTERS | 1 | | L | | | 92.00 |
| 101 0 | 0 10100 HOME HEALTH AGENCY | 1 200 820 | 1 010 | 1 010 | | 1 040 | |
| 101.0 | SPECIAL PURPOSE COST CENTERS | 1,399,829 | 1,910 | 1,910 | 0 | 1,910 | 101.00 |
| 116.0 | 0 11600 HOSPICE | 702 400 | | | | | |
| 118.0 | | 793,490 | 0 | | - 1 | - | 116.00 |
| 110.0 | 100 | 24,654,255 | 93,976 | 68,391 | 155,759 | 66,471 | 118.00 |
| 100.0 | NONREIMBURSABLE COST CENTERS | f | | | , - | | |
| 190.0 | 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 800 | | | 800 | 190.00 |
| 192.0 | 0 19200 PHYSICIANS' PRIVATE OFFICES | 0 | 15,769 | | 0 | 15,769 | 192.00 |
| | 0 07950 FITNESS CENTER | 0 | 3,339 | | 0 | 3,339 | 194.00 |
| | 1 07951 MARKETING | 0 | 242 | 242 | 0 | 242 | 194.01 |
| 194.0 | 2 07952 NEW DIRECTION | 0 | 0 | . 0 | 0 | | 194.02 |
| 194.0 | 3 07953 RESPITE | 0 | 0 | 0 | 0 | 0 | 194.03 |
| | 4 07954 WELL CHILD CLINIC | 0 | 1,322 | 1,322 | o | | 194.04 |
| 200.0 | | | İ | · | | , | 200.00 |
| 201.0 | | | | | i | | 201.00 |
| 202.0 | | 1,235,923 | 1,023,264 | 922,529 | o | 922,947 | |
| | Part I) | ,===,=== | _, = , = 0 , | 522,525 | ٦ | JLL, J47 | 202.00 |
| 203.0 | Unit cost multiplier (Wkst. B. Part I) | 0.050130 | 8.863419 | 10.265949 | 0.000000 | 10.494832 | 203 00 |
| 204.0 | | 17,031 | 184,929 | | 0.000000 | | 204.00 |
| | Part II) | | 201,525 | 113,772 | o _l | 13,707 | 207.00 |
| | ol lasta a martina de | 1 . i | | | | | I |
| 205.0 | O Unit cost multiplier (wkst. B, Part | 0.000691 | 1.601838 | 1.288317 | 0.000000 | 0.178604 | 205 00 |

| | 0 00200 NEW CAP REL COSTS-MVBLE EQUIP 0 00400 EMPLOYEE BENEFITS 0 00561 OTHER ADMINISTRATIVE AND GENERAL 0 00560 BUSINESS OFFICE 0 00600 MAINTENANCE & REPAIRS 0 00700 OPERATION OF PLANT 0 00800 LAUNDRY & LINEN SERVICE 0 00900 HOUSEKEEPING 0 01000 DIETARY 0 01100 CAFETERIA 0 01300 NURSING ADMINISTRATION 0 01400 CENTRAL SERVICES & SUPPLY 0 01500 PHARMACY 0 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS 0 03000 ADULTS & PEDIATRICS 0 04300 NURSERY 0 04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS 0 05000 OPERATING ROOM 0 05100 RECOVERY ROOM 0 05200 DELIVERY ROOM & LABOR ROOM 0 05300 ANESTHESIOLOGY 0 05400 RADIOLOGY-DIAGNOSTIC 0 06600 LABORATORY 0 06300 BLOOD STORING, PROCESSING & TRANS. | | - Trovider | | From 01/01/2012 To 12/31/2012 | Date/Time Pro | epared: |
|--|---|------------------------------|----------------------|--|----------------------------------|--|--|
| ang gamban Pala diri di Agusti di Mangalan di Agusti di Mangalan di Agusti di Mangalan di Agusti di Mangalan di Agusti di Agus | Cost Center Description | DIETARY (MEALS SERVED) | CAFETERIA (HOURS) | NURSING ADMINISTRATIO (DIRECT NRSING HRS) | SUPPLY (COSTED REQUIS.) | 5/29/2013 8:0 PHARMACY (COSTED REQUIS.) | Jo am |
| es are destructions, married states a | CENERAL CONTRE COST CENTERS | 10.00 | 11.00 | 13.00 | 14.00 | 15.00 | |
| 1.00 | | T | | | | | |
| 2.00 4.00 5.01 5.02 6.00 7.00 | 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS 00561 OTHER ADMINISTRATIVE AND GENERAL 00560 BUSINESS OFFICE 00600 MAINTENANCE & REPAIRS | | | | | | 1.00 2.00 4.00 5.01 5.02 6.00 |
| 8.00 9.00 10.00 | 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING | 27.454 | | | | | 7.00 8.00 9.00 |
| | | 37,151 | 200 504 | | | | 10.00 |
| | 1 1 | 0 | 389,501 | \$ | 0 | | 11.00 |
| | | 0 | 4,077 2,101 | | 100 | | 13.00 |
| | | 0 | 18,491 | | 0 0 | | 14.00 |
| | | 0 | 17,742 | | 0 | | |
| | | <u>-</u> | 17,7,72 | 4 | <u> </u> | | 10.00 |
| 30.00 | 03000 ADULTS & PEDIATRICS | 11,956 | 50,544 | 50,54 | 4 0 | 0 | 30.00 |
| 43.00 | 04300 NURSERY | 0 | 0 | · | 0 | | |
| 44.00 | | 16,440 | 30,264 | | 0 0 | 0 | |
| 50.00 | | , | | | | | |
| | | 4,387 | 26,645 | , | | 0 | |
| 52.00 | 05200 RELIVERY ROOM & LABOR ROOM | 0 | 2,038 | | | 0 | |
| 53.00 | 05200 DELIVERY ROOM & LABUR ROOM | 0 | 0 | ' | 0 | 0 | |
| | | 0 718 | 28,912 | 20 01 | 0 | 0 | 1 |
| | | 718 | 2,850 | | 0 | 0 | , |
| | | 2 | 31,013 | | 0 | 0 | |
| 63.00 | 06300 BLOOD STORING, PROCESSING & TRANS. | l ōl | 0 | | 0 | 0 | 63.00 |
| 66.00 | 06600 PHYSICAL THERAPY | 86 | 26,021 | | o o | Ö | |
| 69.00 | 06900 ELECTROCARDIOLOGY | 396 | 20,384 | | 0 | 0 | |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | 1 | 100 | 0 | |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 0 | | 0 | 0 | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 393 | 0 | | 0 | 100 | 73.00 |
| | OUTPATIENT SERVICE COST CENTERS 09000 CLINIC | | | · · · · · · · · · · · · · · · · · · · | | -··· | |
| | 09001 SENIOR CARE | 163 | 4 524 | | 0 | 0 | |
| | 09100 EMERGENCY | 437 1,708 | 4,534 | 1 | 0 | 0 | 90.01 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 1,700 | 28,829 | 28,82 | 9 0 | 0 | 91.00 |
| | OTHER REIMBURSABLE COST CENTERS | | | l | | | 92.00 |
| 101.00 | 10100 HOME HEALTH AGENCY | 15 | | I | 0 | | 101.00 |
| | SPECIAL PURPOSE COST CENTERS | | | | 1 | | 101.00 |
| | 11600 HOSPICE | 0 | 0 | | 0 | 0 | 116.00 |
| 118.00 | | 36,701 | 294,445 | 136,96 | 100 | | 118.00 |
| 100 00 | NONREIMBURSABLE COST CENTERS | | | | | | |
| 190.00 | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES | 0 | 0 | (| 0 | | 190.00 |
| 194 00 | 07950 FITNESS CENTER | 450 | 89,128 | | 0 | | 192.00 |
| | 07951 MARKETING | 0 | 1 760 | 9 | 0 | | 194.00 |
| | 07952 NEW DIRECTION | 0 | 1,768 | | | | 194.01 |
| 194.03 | 07953 RESPITE | 0 | 0 | | | | 194.02 |
| 194.04 | 07954 WELL CHILD CLINIC | 0 | 4,160 | | | | 194.03 194.04 |
| 200.00 | Cross Foot Adjustments | Ÿ | 1,100 | ` | 1 | U | 200.00 |
| 201.00 | Negative Cost Centers | | | | | | 201.00 |
| 202.00 | Cost to be allocated (per Wkst. B, Part I) | 558,860 | 676,472 | · | | 3,420,583 | 202.00 |
| 204.00 | Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, | 15.042933 | 1.736766 | | | 34,205.830000 | 203.00 |
| 204.00 | Part II) | 33,440 | 12,540 | 4,344 | 38,084 | 37,404 | 204.00 |
| 205.00 | Unit cost multiplier (Wkst. B, Part | 0.900110 | 0.032195 | 0 00171 | 200 040000 | 374 040000 | 205 22 |
| | II) | 0.300110 | 0.032193 | 0.031719 | 380.840000 | 374.040000 | 205.00 |

| | | ncial Systems OF RATIO OF COSTS TO CHAR | RGES | WABASH COUNT | Provider | CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | u of Form CMS- Worksheet C Part I Date/Time Pre 5/29/2013 8:0 | pared |
|--------------------------------------|---|---|--|----------------------------|------------------------|------------------------------|---|--|-------------------|
| | | | | | Titl | e XVIII | Hospital | Cost | r |
| | | Cost Center Description | Total Cost (from Wkst. B, Part I, col. | Therapy Limit Adj. | Total Costs | Costs RCE Disallowance | Total Costs | Charges Inpatient | |
| | | | 26) 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 6.00 | |
| | INPAT | IENT ROUTINE SERVICE COST | | | | | | | |
| 30.00 43.00 | | ADULTS & PEDIATRICS NURSERY | 3,339,461 | | 3,339,461 | | 0 3,339,461 | 4,988,845 | |
| | 1 | SKILLED NURSING FACILITY | 1,671,668 | 1 | 0 1,671,668 | | 0 0 1,671,668 | 0 1,276,174 | |
| | ANCIL | LARY SERVICE COST CENTERS | h | | | | 0, 2,0.2,000 | 1,270,171 | 1 77. |
| | | OPERATING ROOM | 2,351,890 | | 2,351,890 | | 0 2,351,890 | 484,828 | 50. |
| 51.00 52.00 | | RECOVERY ROOM DELIVERY ROOM & LABOR | 158,262 | | 158,262 | | 0 158,262 | 71,778 | |
| 32.00 | 03200 | ROOM & LABOR | C | ' | 0 | | 0 | 0 | 52. |
| 53.00 | 05300 | ANESTHESIOLOGY | 104.992 | , | 104,992 | | 0 104,992 | 107,350 | 53 |
| 54.00 | | RADIOLOGY-DIAGNOSTIC | 3,112,237 | , | 3,112,237 | | 0 3,112,237 | 774,146 | |
| 56.00 | | RADIOISOTOPE | 281,459 | | 281,459 | | 0 281,459 | 24,473 | 56. |
| 60.00 | | LABORATORY BLOOD STORING, | 2,717,392 | | 2,717,392 | | 0 2,717,392 | 1,597,188 | |
| | 00300 | PROCESSING & TRANS. | 131,574 | 1 | 131,574 | | 0 131,574 | 79,502 | 63. |
| 66.00 | | PHYSICAL THERAPY | 1,695,651 | . 0 | 1,695,651 | | 0 1,695,651 | 483,342 | 66 |
| 69.00 | | ELECTROCARDIOLOGY | 1,030,744 | | 1,030,744 | | 0 1,030,744 | 814,811 | |
| 71.00 | 07100 | MEDICAL SUPPLIES CHARGED | 2,374,372 | : | 2,374,372 | | 0 2,374,372 | 2,332,801 | |
| 72.00 | 07200 | TO PATIENTS IMPL. DEV. CHARGED TO | 169,507 | , | 169,507 | | 0 169,507 | 453 000 | 7. |
| | 1 | PATIENT | 103,307 | | 103,307 | | 109,307 | 453,688 | 12. |
| 73.00 | | DRUGS CHARGED TO PATIENTS | 3,668,026 | | 3,668,026 | - A | 0 3,668,026 | 4,164,147 | 73. |
| 90.00 | | TIENT SERVICE COST CENTERS CLINIC | 269,343 | | 269,343 | | 0 260 242 | | |
| 0.01 | | SENIOR CARE | 411,922 | | 411,922 | | 0 269,343 0 411,922 | 0 | 90. |
| 91.00 | 09100 | EMERGENCY | 2,812,885 | | 2,812,885 | | 0 2,812,885 | 119,549 | |
| 92.00 | 09200 | OBSERVATION BEDS | 355,592 | | 355,592 | | 355,592 | 0 | |
| | OTHER | (NON-DISTINCT PART) REIMBURSABLE COST CENTERS | | | | | | | |
| 101.00 | 10100 | HOME HEALTH AGENCY | 1,706,865 | | 1,706,865 | | 1,706,865 | | 101 |
| | | AL PURPOSE COST CENTERS | 2,,00,005 | H | 1,700,003 | | 1,700,803 | | 101. |
| | | HOSPICE | 935,359 | | 935,359 | | 935,359 | 0 | 116. |
| 200.00 |) | Subtotal (see instructions) | 29,299,201 | . 0 | 29,299,201 | | 0 29,299,201 | 17,772,622 | 200. |
| 201.00 | | Less Observation Beds | 355,592 | i | 355,592 | | 355 503 | | 201 |
| 202.00 | | Total (see instructions) | 28,943,609 | | 28,943,609 | | 355,592 0 28,943,609 | 17,772,622 | 201. |
| | | | Chai | rges | | | 20,343,003 | 17,772,022 | 202. |
| | | Cost Center Description | Outpatient | Total (col. 6 + col. 7) | Cost or Other Ratio | TEFRA Inpatient Ratio | PPS Inpatient Ratio | | |
| | - | | 7.00 | 8.00 | 9.00 | 10.00 | 11.00 | and the state of t | |
| 0.00 | | IENT ROUTINE SERVICE COST | CENTERS | | | | | | |
| 0.00 | 03000 | ADULTS & PEDIATRICS NURSERY | | 4,988,845 | | | | | 30. |
| 4.00 | 04400 | NURSERY SKILLED NURSING FACILITY | | 0 1,276,174 | | | | | 43. |
| | ANCILI | LARY SERVICE COST CENTERS | | 1,2/0,1/4 | | | | | 44. |
| 0.00 | 05000 | OPERATING ROOM | 3,796,402 | 4,281,230 | 0.549349 | 0.00000 | 0.000000 | | 50. |
| 1.00 | 05100 | RECOVERY ROOM | 330,199 | 401,977 | 0.393709 | 0.00000 | | | 51. |
| 2.00 | 05200 | DELIVERY ROOM & LABOR ROOM | 0 | 0 | 0.000000 | 0.00000 | | | 52. |
| 3.00 | 05300 | ANESTHESIOLOGY | 719,001 | 826,351 | 0 127055 | 0.00000 | 0 00000 | | |
| 4.00 | 05400 | RADIOLOGY-DIAGNOSTIC | 12,962,411 | 13,736,557 | 0.127055 0.226566 | 0.00000 | | | 53. |
| 6.00 | 05600 | RADIOISOTOPE | 1,022,812 | | 0.268751 | 0.00000 | | | 54. 56. |
| 0.00 | | LABORATORY | 9,978,547 | 11,575,735 | 0.234749 | 0.00000 | | | 60. |
| 3.00 | 06300 | BLOOD STORING, | 145,672 | 225,174 | 0.584321 | 0.00000 | | | 63. |
| 6.00 | 06600 | PROCESSING & TRANS. PHYSICAL THERAPY | 2,133,919 | 2,617,261 | 0 647073 | 0.00000 | 0 00000 | | |
| 9.00 | 06900 | ELECTROCARDIOLOGY | 1,470,441 | | 0.647872 0.451042 | 0.00000 | | | 66. |
| 1.00 | 07100 | MEDICAL SUPPLIES CHARGED TO PATIENTS | 2,547,126 | | 0.486559 | 0.00000 | | | 69. 71. |
| | | IMPL. DEV. CHARGED TO PATIENT | 358,419 | 812,107 | 0.208725 | 0.00000 | 0.000000 | | 72. |
| 2.00 | | DRUGS CHARGED TO | 13,952,534 | 18,116,681 | 0.202467 | 0.00000 | 0.000000 | | 73. |
| 2.00 | 07300 | | 13,332,334 | 10,110,001 | 1 | | | | |
| 2.00 | 07300 | PATIENTS | | 20,110,001 | | | | | |
| 2.00 3.00 | 07300 OUTPAT 09000 | PATIENTS FIENT SERVICE COST CENTERS CLINIC | | | 0.341308 | 0 00000 | 0 0 000000 | | 0.0 |
| 2.00 3.00 0.00 0.01 | 07300 OUTPAT 09000 09001 | PATIENTS IENT SERVICE COST CENTERS CLINIC SENIOR CARE | VV Village and an arrange of | 789,149 492,327 | 0.341308 0.836684 | 0.00000 | | | 90. 90. |
| 2.00 3.00 0.00 0.01 1.00 | 07300 OUTPAT 09000 09001 09100 | PATIENTS FIENT SERVICE COST CENTERS CLINIC | 789,149 | 789,149 | | | 0.000000 0.000000 | | 90. 90. 91. |

| Health Finar | ncial Systems | | WABASH COUNT | Y HOSPITAL | | In Lie | u of Form CMS | -2552-10 |
|--------------|-----------------------------|--|----------------------------|---|--|--|---------------|--------------------|
| COMPUTATION | OF RATIO OF COSTS TO CHAR | RGES | | Provi | der CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | | epared: 08 am |
| | | | | | Title XVIII | Hospital | Cost | |
| | | Char | ges | | | | | |
| | Cost Center Description | Outpatient | Total (col. 6 + col. 7) | Cost or Ot Ratio | her TEFRA Inpatient Ratio | PPS Inpatient Ratio | | |
| | | 7.00 | 8.00 | 9.00 | 10.00 | 11.00 | | ****************** |
| OTHER | REIMBURSABLE COST CENTERS | 5 | | *************************************** | | | | |
| 101.00 10100 | HOME HEALTH AGENCY | 1,249,441 | 1,249,441 | I | The state of the s | the term of the template of the contract of th | | 101.00 |
| SPECI | AL PURPOSE COST CENTERS | Anny many transfer and the state of the stat | | | | | | |
| 116.00 11600 | HOSPICE | 1,220,593 | 1,220,593 | | | | | 116.00 |
| 200.00 | Subtotal (see instructions) | 60,217,066 | 77,989,688 | | | | | 200.00 |
| 201.00 | Less Observation Beds | | | | | | | 201.00 |
| 202.00 | Total (see instructions) | 60,217,066 | 77,989,688 | | | | | 202.00 |

| COMPUTA | ATION OF RATIO OF COSTS TO CH | IARGES | WABASH COUNT | | CCN+ 151210 | | u of Form CMS- | LJJL |
|--------------------|--|--------------------------------|--|--|--|----------------------------|--|------------|
| 0 17 | 201 OF TOTAL OF COSTS TO CH | INNUES | | Provider | | Period: From 01/01/2012 | Worksheet C Part I | |
| | | | | | | To 12/31/2012 | Date/Time Pre 5/29/2013 8:0 | epare |
| | | | - | Tit | le xIX | Hospital | PPS | о am |
| | Cost Conton Donnaised | | | | Costs | | Charges | |
| | Cost Center Description | (from Wkst. B, Part I, col. | Therapy Limit Adj. | Total Costs | RCE Disallowance | Total Costs | Inpatient | |
| | | 26) | 2.00 | 3 00 | | | | ļ |
| 1 | INPATIENT ROUTINE SERVICE CO | T CENTERS | 2.00 | 3.00 | 4.00 | 5.00 | 6.00 | |
| 0.00 | 03000 ADULTS & PEDIATRICS | 3,339,461 | | 3,339,461 | | 0 3,339,461 | 4,988,845 | 30 |
| | 04300 NURSERY 04400 SKILLED NURSING FACILIT | 1 671 669 | | 0 | | 0 0 | C | 43 |
| 1.00 | ANCILLARY SERVICE COST CENTER | Υ 1,671,668 RS | The second secon | 1,671,668 | and the state of t | 0 1,671,668 | 1,276,174 | 44 |
| 0.00 | 05000 OPERATING ROOM | 2,351,890 | The state of the s | 2,351,890 | | 0 2,351,890 | 484,828 | 50 |
| 2.00 | 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR | 158,262 | | 158,262 | | 0 158,262 | 71,778 | 51 |
| | ROOM | 1 | | 0 | | 0 | 0 | 52 |
| 3.00 | 05300 ANESTHESIOLOGY | 104,992 | | 104,992 | | 0 104,992 | 107,350 | 53 |
| 6.00 | 05400 RADIOLOGY-DIAGNOSTIC 05600 RADIOISOTOPE | 3,112,237 281,459 | | 3,112,237 281,459 | | 3,112,237 | 774,146 | 54 |
| 0.00 | 06000 LABORATORY | 2,717,392 | | 281,459 | | 0 281,459 0 2,717,392 | 24,473 1,597,188 | |
| 3.00 | 06300 BLOOD STORING, | 131,574 | | 131,574 | | 131,574 | 79,502 | |
| 6.00 | PROCESSING & TRANS. 06600 PHYSICAL THERAPY | 1,695,651 | 0 | 1,695,651 | | 1 505 553 | | |
| 9.00 | 06900 ELECTROCARDIOLOGY | 1.030.744 | | 1,030,744 | | 0 1,695,651 0 1,030,744 | 483,342 814,811 | |
| 1.00 | 07100 MEDICAL SUPPLIES CHARGE TO PATIENTS | D 2,374,372 | | 2,374,372 | | 2,374,372 | 2,332,801 | |
| .00 | 07200 IMPL. DEV. CHARGED TO | 169,507 | | 169,507 | ı | 169 507 | | ļ |
| | PATIENT | | | 109,307 | , | 169,507 | 453,688 | /2 |
| 3.00 | 07300 DRUGS CHARGED TO PATIENTS | 3,668,026 | | 3,668,026 | | 3,668,026 | 4,164,147 | 73 |
| (| OUTPATIENT SERVICE COST CENTE | | | | | | | - |
| 0.00 | 09000 CLINIC 09001 SENIOR CARE | 269,343 | | 269,343 | | 269,343 | 0 | 90 |
| 1.00 | 09100 EMERGENCY | 411,922 2,812,885 | | 411,922 | 9 | 411,922 | 0 | |
| 2.00 | 09200 OBSERVATION BEDS | 355,592 | | 2,812,885 355,592 | (| 2,812,885 355,592 | 119,549 0 | 1 |
| ļ | (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTE | n. | | , | | 333,332 | | 32 |
| 01.00[1 | 10100 HOME HEALTH AGENCY | 1,706,865 | | 1,706,865 | | 1,706,865 | | 100 |
| 5 | SPECIAL PURPOSE COST CENTERS | | | 1,700,005 | | 1,700,803 | 0 | 101 |
| 00.00 | 11600 HOSPICE Subtotal (see | 935,359 29,299,201 | | 935,359 | | 935,359 | | 116 |
| | instructions) | 29,299,201 | 0 | 29,299,201 | (| 29,299,201 | 17,772,622 | 200. |
| 01.00 | Less Observation Beds | 355,592 | | 355,592 | | 355,592 | | 201. |
| 72.00 | Total (see instructions | 28,943,609 Char | 0 | 28,943,609 | (| 28,943,609 | 17,772,622 | |
| | Cost Center Description | | Total (col. 6 | Cost or Other | TEFRA | PPS Inpatient | V. 1-16-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1- | |
| | | | + col. 7) | Ratio | Inpatient | Ratio | | |
| | | 7.00 | 8.00 | 9.00 | Ratio | 11 00 | | |
| I | INPATIENT ROUTINE SERVICE COS | T CENTERS | 0.00 | 3.00 | 10.00 | 11.00 | | |
| .00 0 | 03000 ADULTS & PEDIATRICS 04300 NURSERY | | 4,988,845 | | | | | 30. |
| .00 [0 | 04400 SKILLED NURSING FACILITY | | 0 1,276,174 | | | | | 43. |
| Α | ANCILLARY SERVICE COST CENTER | 5 | | | | | | 44. |
| .00 0 | 05000 OPERATING ROOM 05100 RECOVERY ROOM | 3,796,402 | 4,281,230 | 0.549349 | 0.000000 | | | 50. |
| .00 0 | 05200 DELIVERY ROOM & LABOR | 330,199 | 401,977 0 | 0.393709 | 0.000000 | | | 51. |
| | ROOM | | J | 0.000000 | 0.000000 | 0.000000 | | 52. |
| .00 0 .00 0 | 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC | 719,001 | 826,351 | 0.127055 | 0.000000 | | | 53. |
| .00 0 | 05600 RADIOISOTOPE | 12,962,411 1,022,812 | 13,736,557 1,047,285 | 0.226566 0.268751 | 0.000000 | | | 54. |
| .00 0 | 06000 LABORATORY | 9,978,547 | 11,575,735 | 0.234749 | 0.000000 | | | 56. 60. |
| .00 0 | D6300 BLOOD STORING, PROCESSING & TRANS. | 145,672 | 225,174 | 0.584321 | 0.000000 | | | 63. |
| .00 0 | 06600 PHYSICAL THERAPY | 2,133,919 | 2,617,261 | 0.647872 | 0.000000 | 0 647073 | | |
| .00 0 | 06900 ELECTROCARDIOLOGY | 1,470,441 | 2,285,252 | 0.451042 | 0.000000 | | i | 66. 69. |
| .00 0 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 2,547,126 | 4,879,927 | 0.486559 | 0.000000 | | | 71. |
| .00 0 | 07200 IMPL. DEV. CHARGED TO | 358,419 | 812,107 | 0.208725 | 0.000000 | 0 200725 | 1 | |
| | PATIENT 07300 DRUGS CHARGED TO | | | | 0.00000 | 0.208725 | | 72. |
| | PATIENTS | 13,952,534 | 18,116,681 | 0.202467 | 0.000000 | 0.202467 | | 73. |
| OL CI | SUTPATIENT SERVICE COST CENTER | | | The state of the s | | | | |
| .00 09 .01 09 | 9000 CLINIC 9001 SENIOR CARE | 789,149 | 789,149 | 0.341308 | 0.000000 | 0.341308 | | 90. |
| .00 09 | 9100 EMERGENCY | 492,327 6,132,647 | 492,327 6,252,196 | 0.836684 | 0.000000 | 0.836684 | İ | 90.0 |
| .00 09 | 9200 OBSERVATION BEDS | 915,426 | 915,426 | 0.449904 0.388444 | 0.000000 | 0.449904 0.388444 | | 91.0 |
| | (NON-DISTINCT PART) | | | | 2.000000 | 0.300444 | | 92.0 |

| Health Fina | ncial Systems | | WABASH COUNT | TY HOS | PITAL | | In Lie | u of Form CMS | -2552-10 |
|--------------|-----------------------------|------------|----------------------------|--------|---|--|---|--|----------|
| COMPUTATION | OF RATIO OF COSTS TO CHAR | RGES | | | Provider | CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | | |
| | | | | | Tit | le XIX | Hospital | PPS | |
| | | Char | rges | | | | | | |
| | Cost Center Description | Outpatient | Total (col. 6 + col. 7) | 1 | or Other Ratio | TEFRA Inpatient Ratio | PPS Inpatient Ratio | of the second control of the second s | |
| | | 7.00 | 8.00 | | 9.00 | 10.00 | 11.00 | | |
| | R REIMBURSABLE COST CENTERS | S | | | | | | | |
| 101.00 10100 | HOME HEALTH AGENCY | 1,249,441 | 1,249,441 | נו | | The second secon | | A STATE OF A COMMON OF THE STATE OF THE STAT | 101.00 |
| SPEC | TAL PURPOSE COST CENTERS | | | | restriction of the second second second | | | | |
| 116.00 11600 | HOSPICE | 1,220,593 | 1,220,593 | 3 | | | T | | 116.00 |
| 200.00 | Subtotal (see instructions) | 60,217,066 | | | | | | | 200.00 |
| 201.00 | Less Observation Beds | | | | | | | | 201.00 |
| 202.00 | Total (see instructions) | 60,217,066 | 77,989,688 | 3 | | | 1 | | 202.00 |

REDUCTIONS FOR MEDICAID ONLY

| | TONS FOR PREDICATE ONE! | | | | 0 12/31/2012 | Date/Time Pre 5/29/2013 8:0 | |
|--------|--|--|----------------|---------------------------------------|--------------|--------------------------------|--------|
| | Cost Center Description | Total Cost | | le XIX Operating Cost | Hospital | PPS | 1 |
| | cost center bescription | | (Wkst. B, Part | | | Operating Cost Reduction | |
| | | I, col. 26) | | Cost (col. 1 - | Reduction | Amount | |
| | | 1, (01. 20) | 11 (01. 20) | col. 2) | | Amount | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | T |
| | 05000 OPERATING ROOM | 2,351,890 | 180,894 | 2,170,996 | 0 | 0 | 50.00 |
| 51.00 | 05100 RECOVERY ROOM | 158,262 | 6,506 | | | 0 | 1 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | 0 | o | Ō | |
| 53.00 | 05300 ANESTHESIOLOGY | 104,992 | 2,488 | 102,504 | o | Ō | 53.00 |
| 54.00 | 05400 RADIOLOGY-DIAGNOSTIC | 3,112,237 | | | | ñ | 54.00 |
| 56.00 | 05600 RADIOISOTOPE | 281,459 | 2,556 | | i I | 0 | 56.00 |
| 60.00 | 06000 LABORATORY | 2,717,392 | 64,369 | | | o 0 | 60.00 |
| 63.00 | 06300 BLOOD STORING, PROCESSING & TRANS. | 131,574 | | | 1 -1 | o O | 63.00 |
| 66.00 | 06600 PHYSICAL THERAPY | 1,695,651 | 22,949 | | | o o | I |
| 69.00 | 06900 ELECTROCARDIOLOGY | 1,030,744 | | , , | _ | ñ | 69.00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 2,374,372 | , | 2,330,207 | | ñ | 71.00 |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENT | 169,507 | , , | | 1 | ő | |
| | 07300 DRUGS CHARGED TO PATIENTS | 3,668,026 | , , | | | ő | i |
| | OUTPATIENT SERVICE COST CENTERS | 1 | | | | | 73.00 |
| 90.00 | 09000 CLINIC | 269,343 | 17,783 | 251,560 | 0 | 0 | 90.00 |
| 90.01 | 09001 SENIOR CARE | 411,922 | | | | ň | 90.01 |
| 91.00 | 09100 EMERGENCY | 2,812,885 | | 2,765,714 | 2 | ň | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 355,592 | , | 355,592 | | ŏ | |
| | OTHER REIMBURSABLE COST CENTERS | The state of the s | | | | | 32.00 |
| 101.00 | 10100 HOME HEALTH AGENCY | 1,706,865 | 20,435 | 1,686,430 | 0 | | 101.00 |
| | SPECIAL PURPOSE COST CENTERS | | | an an en was fait in the first of the | | | 101.00 |
| | 11600 HOSPICE | 935,359 | 5,147 | 930,212 | ol | 0 | 116.00 |
| 200.00 | 1 | 24,288,072 | , , | | | | 200.00 |
| 201.00 | Less Observation Beds | 355,592 | , | 355,592 | i I | | 201.00 |
| 202.00 | Total (line 200 minus line 201) | 23,932,480 | , | | l I | | 202.00 |

| Health Financ | | WABASH COUNT | Y HOSPITAL | | In Lie | u of Form CMS | -2552-10 |
|----------------|--|----------------|----------------|---------------|-----------------|------------------------------|----------|
| | OF OUTPATIENT SERVICE COST TO CHARGE F | RATIOS NET OF | Provider | CCN: 151310 | Period: | Worksheet C | |
| REDUCTIONS FO | OR MEDICAID ONLY | | | | From 01/01/2012 | Part II | |
| | | | | | To 12/31/2012 | Date/Time Pr 5/29/2013 8: | |
| | | | Tit | le XIX | Hospital | PPS | UO AIII |
| (| Cost Center Description | Cost Net of | Total Charges | Outpatient | | | |
| | | Capital and | (Worksheet C, | Cost to Charg | ge | | |
| | | Operating Cost | Part I, column | Ratio (col. | 6 | | |
| | | Reduction | 8) | / col. 7) | | | |
| | | 6.00 | 7.00 | 8.00 | | | |
| | ARY SERVICE COST CENTERS | | | | | | |
| | OPERATING ROOM | 2,351,890 | | 0.54934 | 49 | | 50.00 |
| | RECOVERY ROOM | 158,262 | 401,977 | 0.39370 | 09 | | 51.00 |
| | DELIVERY ROOM & LABOR ROOM | 0 | 0 | 0.00000 | 00 | | 52.00 |
| | ANESTHESIOLOGY | 104,992 | 826,351 | 0.1270 | 55 | | 53.00 |
| | RADIOLOGY-DIAGNOSTIC | 3,112,237 | 13,736,557 | 0.22656 | 56 | | 54.00 |
| | RADIOISOTOPE | 281,459 | 1,047,285 | 0.2687 | 51 | | 56.00 |
| | LABORATORY | 2,717,392 | 11,575,735 | 0.23474 | 19 | | 60.00 |
| | BLOOD STORING, PROCESSING & TRANS. | 131,574 | 225,174 | 0.58432 | 21 | | 63.00 |
| | PHYSICAL THERAPY | 1,695,651 | 2,617,261 | 0.64787 | 72 | | 66.00 |
| | ELECTROCARDIOLOGY | 1,030,744 | 2,285,252 | 0.45104 | 12 | | 69.00 |
| | MEDICAL SUPPLIES CHARGED TO PATIENTS | 2,374,372 | 4,879,927 | 0.4865 | 59 | | 71.00 |
| | IMPL, DEV. CHARGED TO PATIENT | 169,507 | 812,107 | 0.20872 | 25 | | 72.00 |
| 73.00 07300 r | DRUGS CHARGED TO PATIENTS | 3,668,026 | 18,116,681 | 0.20246 | 57 | | 73.00 |
| | IENT SERVICE COST CENTERS | | | | | | |
| 90.00 09000 0 | | 269,343 | 789,149 | 0.34130 | 08 | | 90.00 |
| | SENIOR CARE | 411,922 | 492,327 | 0.83668 | 34 | | 90.01 |
| | EMERGENCY | 2,812,885 | 6,252,196 | 0.44990 | 04 | | 91.00 |
| | DBSERVATION BEDS (NON-DISTINCT PART) | 355,592 | 915,426 | 0.38844 | 14 | | 92.00 |
| | REIMBURSABLE COST CENTERS | | | | | | 1 |
| | HOME HEALTH AGENCY | 1,706,865 | 1,249,441 | 1.36610 |)3 | | 101.00 |
| | L PURPOSE COST CENTERS | | | | | | |
| 116.00 11600 H | | 935,359 | 1,220,593 | 0.76632 | 1.5 | | 116.00 |
| | Subtotal (sum of lines 50 thru 199) | 24,288,072 | 71,724,669 | | | | 200.00 |
| | Less Observation Beds | 355,592 | 0 | | | | 201.00 |
| 202.00 | Total (line 200 minus line 201) | 23,932,480 | 71,724,669 | | | | 202.00 |

| | | | | From 01/01/2012 To 12/31/2012 | Part II Date/Time Pre 5/29/2013 8:0 | |
|--|--|---|---------|----------------------------------|---|--------|
| | | | e XVIII | Hospital | Cost | |
| Cost Center Description | Capital | Total Charges | | Inpatient | Capital Costs | |
| | | (from Wkst. C, | | Program | (column 3 x | |
| | (from Wkst. B, | | | . Charges | column 4) | [|
| | Part II, col. 26) | 8) | 2) | | | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| ANCILLARY SERVICE COST CENTERS | | | | | | _ |
| 50.00 05000 OPERATING ROOM | 180,894 | 4,281,230 | 0.04225 | 170,885 | 7,220 | 50.00 |
| 51.00 05100 RECOVERY ROOM | 6,506 | 401,977 | 0.01618 | 5 25,367 | 411 | 51.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | 0.00000 | 0 | 0 | 52.00 |
| 53.00 05300 ANESTHESIOLOGY | 2,488 | 826,351 | 0.00301 | 1 26,665 | 80 | 53.00 |
| 54.00 05400 RADIOLOGY-DIAGNOSTIC | 225,361 | 13,736,557 | 0.01640 | 6 359,451 | 5,897 | 54.00 |
| 56.00 05600 RADIOISOTOPE | 2,556 | 1,047,285 | 0.00244 | 10,235 | 25 | 56.00 |
| 60.00 06000 LABORATORY | 64,369 | 11,575,735 | 0.00556 | 754,962 | 4,198 | 60.00 |
| 63.00 06300 BLOOD STORING, PROCESSING & TRANS. | 745 | 225,174 | 0.00330 | 9 73,323 | | |
| 66.00 06600 PHYSICAL THERAPY | 22,949 | 2,617,261 | 0.00876 | 8 83,718 | 734 | 66.00 |
| 69.00 06900 ELECTROCARDIOLOGY | 25,863 | 2,285,252 | 0.01131 | 7 400,678 | 4,534 | 69.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 44,165 | 4,879,927 | 0.00905 | 0 704,899 | | |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 1,130 | 812,107 | 0.00139 | 1 111,403 | | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 44,898 | 18,116,681 | 0.00247 | 8 2,153,570 | 5,337 | |
| OUTPATIENT SERVICE COST CENTERS | The state of the s | to an out and a service and a | | | | |
| 90.00 09000 CLINIC | 17,783 | 789,149 | 0.02253 | 4 0 | 0 | 90.00 |
| 90.01 09001 SENIOR CARE | 14,576 | 492,327 | | | 0 | 90.01 |
| 91.00 09100 EMERGENCY | 47,171 | 6,252,196 | 0.00754 | 5 2,535 | 19 | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 915,426 | | | 0 | |
| 200.00 Total (lines 50-199) | 701,454 | 69,254,635 | | 4,877,691 | 35,232 | 200.00 |

| APPORT | IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE | WABASH COUNT | c D | | CCN: 151310 | Period: | | u of Form CMS- | |
|--------|--|--|--|--------|--------------|-----------|--------|------------------------|--------|
| THROUG | H COSTS | KVICE OINER PAS | 13 | ovider | CCM: 131310 | From 01/0 | 1/2012 | Worksheet D Part IV | |
| | | | | | | | 1/2012 | | nared: |
| | | | | | | , | _, | 5/29/2013 8:0 | 8 am |
| | | | | | e XVIII | Hospi | ta1 | Cost | |
| | Cost Center Description | Non Physician | Nursing | School | Allied Healt | h A11 0 | ther | Total Cost | |
| | | Anesthetist | | | | Medi | cal | (sum of col 1 | l |
| | | Cost | | | | Education | n Cost | through col. | |
| | | | | | | | | 4) | |
| | | 1.00 | 2. | 00 | 3.00 | 4.0 | 00 | 5.00 | |
| | ANCILLARY SERVICE COST CENTERS | entigenmente en en en santante e transmissionem ingeneratura en generatura en en en en en en en en en en en en | e la fraillea promocure e promocure anno conse | | | | | | |
| | 05000 OPERATING ROOM | |) | 0 | 4 | 0 | 0 | 0 | 50.00 |
| | 05100 RECOVERY ROOM | C |) | 0 | 4 | 0 | 0 | 0 | 51.00 |
| | 05200 DELIVERY ROOM & LABOR ROOM | C |) | 0 | / | 0 | 0 | 0 | 52.00 |
| | 05300 ANESTHESIOLOGY | 0 |) | 0 | / | 0 | 0 | 0 | 53.00 |
| | 05400 RADIOLOGY-DIAGNOSTIC | 0 |) | 0 | 1 | 0 | 0 | 0 | 54.00 |
| | 05600 RADIOISOTOPE | 0 |) | 0 | 1 | 0 | 0 | 0 | 56.00 |
| | 06000 LABORATORY | 0 |) | 0 | 4 | 0 | 0 | 0 | 60.00 |
| 63.00 | 06300 BLOOD STORING, PROCESSING & TRANS. | 0 |) | 0 | 1 | 0 | 0 | 0 | 63.00 |
| | 06600 PHYSICAL THERAPY | 0 |) | 0 | 4 | 0 | 0 | 0 | 66.00 |
| | 06900 ELECTROCARDIOLOGY | 0 |) | 0 | 4 | 0 | 0 | 0 | 69.00 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | | 0 | · | 0 | 0 | 0 | 71.00 |
| | 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | | 0 | 4 | 0 | 0 | 0 | 72.00 |
| | 07300 DRUGS CHARGED TO PATIENTS | 0 |) | 0 | f | 0 | 0 | 0 | 73.00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | | |
| | 09000 CLINIC | 0 | | 0 | | 0 | 0 | 0 | 90.00 |
| | 09001 SENIOR CARE | 0 | | 0 | , | 0 | 0 | 0 | |
| | 09100 EMERGENCY | 0 | | 0 | , | 0 | 0 | 0 | |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 |) | 0 | , | 0 | 0 | 0 | |
| 200.00 | Total (lines 50-199) | 0 | | 0 | i | ol | 0 | 0 | 200.00 |

| | Financial Systems | WABASH COUNT | | PITAL | | In Lie | u of Form CMS-2 | 2552-1 |
|------|--|----------------------------|---------------|------------------------|--|---|---------------------------------|----------------|
| | IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI H COSTS | RVICE OTHER PAS | S | Provider | | Period: From 01/01/2012 To 12/31/2012 | | pared: 8 am |
| | | | | Titl | e XVIII | Hospital | Cost | |
| | Cost Center Description | Cost (sum of col. 2, 3 and | (from Part | Wkst. C, | Ratio of Cost to Charges (col. 5 ÷ col 7) | Ratio of Cost to Charges (col. 6 ÷ col. | Inpatient Program Charges | |
| | | 4) | | | | 7) | | |
| | ANCT LADY CERTIFIC COCY COURSE | 6.00 | <u> </u> | 7.00 | 8.00 | 9.00 | 10.00 | |
| | ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM | T | T | . 201 220 | | 0 000000 | | |
| | 05100 RECOVERY ROOM | 0 | | 4,281,230 | | | . , | |
| | 05200 DELIVERY ROOM & LABOR ROOM | 0 | | 401,977 | | | / | 51.00 |
| 3.00 | 05300 ANESTHESIOLOGY | 0 | | 026 251 | 0.00000 | | - | 52.00 |
| | 05400 RADIOLOGY-DIAGNOSTIC | 0 | ١ , | 826,351 | | 1 | . , | 53.00 |
| | 05600 RADIOISOTOPE | 0 | l . | 3,736,557 | | -1 | , | 54.00 |
| | 06000 LABORATORY | 0 | l . | 1,047,285 | | | - , | |
| | 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | 1 | 1,575,735 | i . | | 754,962 | 60.00 |
| | 06600 PHYSICAL THERAPY | | | 225,174 | | | , | i |
| | 06900 ELECTROCARDIOLOGY | 0 | | 2,617,261 2,285,252 | | | , | |
| 1.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | | | l . | | 400,678 | |
| | 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | | 4,879,927 812,107 | | | , | |
| | 07300 DRUGS CHARGED TO PATIENTS | | 1. | 812,107 8,116,681 | | | , | |
| | OUTPATIENT SERVICE COST CENTERS | | L | 0,110,001 | 0.00000 | 0.000000 | 2,153,570 | 73.00 |
| 0 00 | 00000 CLTNTC | Ţ | | | | | | ľ |

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789,149 492,327

6,252,196

915,426 69,254,635

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0.000000 0.000000

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0.000000

90.00 0

0 90.01

2,535 91.00 0 92.00

4,877,691 200.00

90.00 09000 CLINIC

90.01 09001 SENIOR CARE

91.00 | 09100| EMERGENCY | 92.00 | 09200 | 095ERVATION BEDS (NON-DISTINCT PART) | 200.00 | Total (lines 50-199)

Total (lines 50-199)

| ADDODT | TOWNENT OF THRATTCHY (OUTRATTENT ASSESSMENT | | | | | u of Form CMS- | |
|--------|--|--|----------------------------------|--|---|----------------------------|---------|
| | IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI H COSTS | RVICE OTHER PASS | 5 Provider | CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | | |
| | | | Titl | e XVIII | Hospital | Cost | |
| | Cost Center Description | Inpatient Program Pass-Through Costs (col. 8 x col. 10) | Outpatient Program Charges | Outpatient Program Pass-Through Costs (col. x col. 12) | n Anesthetist | PSA Adj. Nursing School | |
| | The state of the s | 11.00 | 12.00 | 13.00 | 21.00 | 22.00 | |
| | ANCILLARY SERVICE COST CENTERS | Carrier Carrier Co. Carrier States and Administration productions of | | · | | | |
| | 05000 OPERATING ROOM | 0 | 0 |) | 0 | 0 | 50.00 |
| | 05100 RECOVERY ROOM | 0 | 0 | | 0 | 0 | 51.00 |
| | 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 |) | 0 | 0 | 52.00 |
| | 05300 ANESTHESIOLOGY | 0 | 0 |) | 0 | 0 | 53.00 |
| | 05400 RADIOLOGY-DIAGNOSTIC | 0 | 0 |) | 0 | 0 | 54.00 |
| | 05600 RADIOISOTOPE | 0 | 0 |) | 0 | 0 | 56.00 |
| | 06000 LABORATORY | 0 | O |) | 0 | 0 | 60.00 |
| | 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | 0 |) | 0 | 0 | 63.00 |
| | 06600 PHYSICAL THERAPY | 0 | 0 |) | 0 | 0 | 66.00 |
| | 06900 ELECTROCARDIOLOGY | 0 | Ü |) | 0 | 0 | 69.00 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | U | | 0 | 0 | 71.00 |
| | 07300 DRUGS CHARGED TO PATIENTS | 0 | Ü | | 0 | 0 | 72.00 |
| | OUTPATIENT SERVICE COST CENTERS | <u> </u> | | <u>'L</u> | 0 | 0 | 73.00 |
| | 09000 CLINIC | 0 | | · | | | 00.00 |
| | 09001 SENIOR CARE | 0 | 0 | | 0 | 0 | 90.00 |
| | 09100 EMERGENCY | 0 | 0 | | 0 | 0 | |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | 0 | 0 | 91.00 |
| | (NON DISTINCT TAKT) | 1 | | '1 | U | i U | 1 92.00 |

| | Financial Systems | WABASH COUNT | | PITAL | | In Lie | u of Form CMS | -2552-10 |
|--------|---|---------------------------|-------|---|-------------|---|--|----------|
| | TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE H COSTS | RVICE OTHER PAS | S | | CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV Date/Time Pr 5/29/2013 8: | |
| | | | | with an experience that there is a recover a resident and the contract of | le XVIII | Hospital | Cost | |
| | Cost Center Description | PSA Adj. Allied Health | Other | Adj. All Medical tion Cosi | 1 | | | |
| | | 23.00 | | 4.00 | 1 | | | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | |
| | 05000 OPERATING ROOM | 0 | | (| | | | 50.00 |
| | 05100 RECOVERY ROOM | 0 | | (|) | | | 51.00 |
| | 05200 DELIVERY ROOM & LABOR ROOM | 0 | | (|) | | | 52.00 |
| 53.00 | 05300 ANESTHESIOLOGY | 0 | | (| | | | 53.00 |
| 54.00 | 05400 RADIOLOGY-DIAGNOSTIC | 0 | Ì | (| o | | | 54.00 |
| 56.00 | 05600 RADIOISOTOPE | 0 | | (|) | | | 56.00 |
| 60.00 | 06000 LABORATORY | 0 | | (| | | | 60.00 |
| 63.00 | 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | | (|) | | | 63.00 |
| | 06600 PHYSICAL THERAPY | 0 | | (| | | | 66.00 |
| 69.00 | 06900 ELECTROCARDIOLOGY | 0 | | (| | | | 69.00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | | (| | | • | 71.00 |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENT | 1 0 | | (| | | | 72.00 |
| | 07300 DRUGS CHARGED TO PATIENTS | 0 | | (| | | | 73.00 |
| | OUTPATIENT SERVICE COST CENTERS | * | | | | V V A | | 7 . 3.00 |
| | 09000 CLINIC | 0 | | (| <u> </u> | | | 90.00 |
| | 09001 SENIOR CARE | 0 | | (|) | | | 90.01 |
| | 09100 EMERGENCY | 0 | | (|) | | | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | | (| | | | 92.00 |
| 200.00 | | 0 | | (| ol . | | | 200.00 |

18,850,641

18,850,641

143

0

143

0 200.00

0 202.00

201.00

0

0

200.00

201.00

202.00

Subtotal (see instructions)

Only Charges

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 +/- line 201)

| APPORTIONME | NT OF MEDICAL, OTHER HEALTH SERVICES AND | O VACCINE COST | | CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V Date/Time Pre 5/29/2013 8:0 | epared)8 am |
|----------------|--|--|--------------------|-------------|---|---|-----------------|
| | | The same starting are a same starting and the same starting and the same starting are same as a same starting at the same starting at t | | e XVIII | Hospital | Cost | |
| | Cost Center Description | Cost Reimbursed | Cost Reimbursed | | | | |
| | | Services | Services Not | | | | |
| | | Subject To | Subject To | | | | |
| | | Ded. & Coins. | | | | | |
| | | (see inst.) | (see inst.) | | | | |
| | | 6.00 | 7.00 | | | | |
| ANCIL | LARY SERVICE COST CENTERS | | | | | | |
| 0.00 05000 | OPERATING ROOM | 503,111 | 0 | | 1-1-2-1-2-1-2-1-2-1-2-1-1-1-1-1-1-1-1-1 | | 50.0 |
| 1.00 05100 | RECOVERY ROOM | 29,086 | 0 | | | | 51.0 |
| | DELIVERY ROOM & LABOR ROOM | 0 | 0 | | | | 52. |
| | ANESTHESIOLOGY | 15,050 | 0 | | | | 53. |
| 4.00 05400 | RADIOLOGY-DIAGNOSTIC | 941,111 | 0 | | | | 54. |
| | RADIOISOTOPE | 110,901 | 0 | | | | 56. |
| | LABORATORY | 864,763 | 0 | | | | 60. |
| | BLOOD STORING, PROCESSING & TRANS. | 83,556 | 0 | | | | 63. |
| | PHYSICAL THERAPY | 387,984 | 0 | | | | 66. |
| | ELECTROCARDIOLOGY | 281,480 | 0 | | | | 69. |
| | MEDICAL SUPPLIES CHARGED TO PATIENTS | 274,206 | 0 | | | | 71. |
| | IMPL. DEV. CHARGED TO PATIENT | 14,854 | 0 | | | | 72. |
| | DRUGS CHARGED TO PATIENTS | 1,157,538 | 29 | | | | 73. |
| 001PA 09000 | TIENT SERVICE COST CENTERS | | | , | | | |
| | SENIOR CARE | 0 | 0 | | | | 90. |
| | SENIOR CARE EMERGENCY | 341,513 | 0 | | | | 90. |
| | OBSERVATION BEDS (NON-DISTINCT PART) | 559,536 | 0 | | | | 91. |
| 00.00 | Subtotal (see instructions) | 47,614 | | | | | 92. |
| 01.00 | Less PBP Clinic Lab. Services-Program | 5,612,303 | 29 | | | | 200. |
| 51.00 | Only Charges | U | | | | | 201. |
| i i | pointy charges | 1 | | 1 | | | 1 |

| APPORTIONMENT | OF MEDICAL, OTHER HEALTH SERVICES AND | VACCINE COST | Provider | | Period: | Worksheet D | |
|----------------|---------------------------------------|----------------|---------------|---------------|----------------------------------|---------------------------|---------|
| | | | Component | CCN: 15Z310 | From 01/01/2012 To 12/31/2012 | Part V Date/Time Pre | nared: |
| | | | | | | 5/29/2013 8:0 | 8 am |
| | | | Titl | | wing Beds - SNF | | - |
| _ | | | | Charges | | Costs | |
| Co | ost Center Description | Cost to Charge | | | Cost | PPS Services | |
| | | Ratio From | Services (see | | Reimbursed | (see inst.) | 1 |
| | | Worksheet C, | inst.) | Services | Services Not | | |
| | | Part I, col. 9 | | Subject To | Subject To | | |
| | | | | | Ded. & Coins. | | |
| | | 1,00 | 2.00 | (see inst.) | (see inst.) | | |
| ANCTLLA | RY SERVICE COST CENTERS | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | ļ |
| | PERATING ROOM | 0.549349 | | J | | | |
| | ECOVERY ROOM | 0.393709 | | | 0 | 0 | |
| | ELIVERY ROOM & LABOR ROOM | 0.000000 | 1 |) | | 0 | 1 |
| | NESTHESIOLOGY | 0.127055 | |) | | 0 | |
| | ADIOLOGY-DIAGNOSTIC | 0.226566 | _ | | | 0 | |
| | ADIOISOTOPE | 0.268751 | | | | 0 | |
| | ABORATORY | 0.234749 | | | | 0 | |
| 63.00 06300 ві | LOOD STORING, PROCESSING & TRANS. | 0.584321 | _ | 1 | | 0 | |
| 66.00 06600 PH | HYSICAL THERAPY | 0.647872 | - | ì | ก | 0 | 1 |
| | LECTROCARDIOLOGY | 0.451042 | _ | ì | | 0 | |
| 71.00 07100 ME | EDICAL SUPPLIES CHARGED TO PATIENTS | 0.486559 | | 1 | o o | 0 | |
| | MPL. DEV. CHARGED TO PATIENT | 0.208725 | l . | i | | 0 | |
| 73.00 07300 DF | RUGS CHARGED TO PATIENTS | 0.202467 | Ō | ĺ | o o | ő | , |
| OUTPATI | ENT SERVICE COST CENTERS | | | · | | | 1 73.00 |
| 90.00 09000 CL | | 0.341308 | 0 | (| 0 | 0 | 90.00 |
| | ENIOR CARE | 0.836684 | o | Ò | ol o | ő | |
| 91.00 09100 EM | | 0.449904 | o | | ol ol | 0 | |
| | BSERVATION BEDS (NON-DISTINCT PART) | 0.388444 | 0 | (| ol ol | ō | 1 |
| | ubtotal (see instructions) | | 0 | (| o o | ō | 200.00 |
| 201.00 Le | ess PBP Clinic Lab. Services-Program | | | (| ol ol | | 201.00 |
| | nly Charges | | | | | | |
| 202.00 Ne | et Charges (line 200 +/- line 201) | | 0 | (| 0 | 0 | 202.00 |

0

| | Financial Systems | WABASH COUNT | | | | u of Form CMS- | 2552-10 |
|--------|---|-----------------|----------------|---------------|----------------------------------|----------------|---------|
| | TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE | RVICE OTHER PAS | S Provider | CCN: 151310 | Period: | Worksheet D | |
| THROUG | SH COSTS | | Componen: | t CCN: 155365 | From 01/01/2012 To 12/31/2012 | | narod: |
| | | | Componen | c ccn, 155505 | 10 12/31/2012 | 5/29/2013 8:0 | |
| | | | Titl | e XVIII | Skilled Nursing | PPS | |
| | | | | - | Facility | *** | |
| | Cost Center Description | | Nursing School | Allied Healt | | Total Cost | |
| | | Anesthetist | | | Medical | (sum of col 1 | |
| | | Cost | | | Education Cost | | |
| | | 1,00 | 2.00 | 3,00 | 4.00 | 4) 5.00 | - |
| | ANCILLARY SERVICE COST CENTERS | 1.00 | 1.00 | 1 | 1 4.00 | 3.00 | |
| 50.00 | 05000 OPERATING ROOM | 0 | 0 |) | 0 0 | 0 | 50.00 |
| 51.00 | 05100 RECOVERY ROOM | 0 | o | | 0 0 | ٥ | 51.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | O | | 0 0 | o o | 52.00 |
| 53.00 | 05300 ANESTHESIOLOGY | 0 | 0 | | 0 0 | 0 | 53.00 |
| 54.00 | 05400 RADIOLOGY-DIAGNOSTIC | 0 | 0 |) | 0 0 | o o | 54.00 |
| 56.00 | 05600 RADIOISOTOPE | 0 | o |) | 0 | o | 56.00 |
| 60.00 | 06000 LABORATORY | 0 | o |) | 0 0 | 0 | 60.00 |
| 63.00 | 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | 0 |) | 0 0 | 0 | 63.00 |
| 66.00 | 06600 PHYSICAL THERAPY | 0 | 0 |) | 0 0 | 0 | 66.00 |
| 69.00 | 06900 ELECTROCARDIOLOGY | 0 | 0 |) | 0 | 0 | 69.00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | 0 | 0 | 71.00 |
| | 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 0 | | 0 | 0 | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 |) <u> </u> | 0 | 0 | 73.00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| | 09000 CLINIC | 0 | 0 | | 0 0 | 0 | 90.00 |
| | 09001 SENIOR CARE | 0 | 0 | 1 | 0 | 0 | 90.01 |
| | 09100 EMERGENCY | 0 | 0 |) | 0 0 | 0 | 91.00 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 0 | 1 | 0 | 0 | 92.00 |
| 200.00 | Total (lines 50-199) | 0 |) 0 | l e | 0 | 0 | 200.00 |

| | Financial Systems | WABASH COUNT | | | | | u of Form CMS- | 255 <u>2-10</u> |
|--------|---|-----------------|------|----------------------------|---------------|----------------------------------|-----------------------------|-----------------|
| | IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER | RVICE OTHER PAS | S | Provider | | Period: | Worksheet D | |
| THROUG | H COSTS | | | Component | | From 01/01/2012 To 12/31/2012 | Part IV | |
| | | | | Componen | r CCM* 133303 | To 12/31/2012 | Date/Time Pre 5/29/2013 8:0 | |
| | | | | Titl | e XVIII | Skilled Nursing | PPS | <u> </u> |
| | | | | -and marrows may and amous | | Facility | | |
| | Cost Center Description | Total | | | Ratio of Cos | | Inpatient | |
| | | | | | to Charges | Ratio of Cost | Program | |
| | | Cost (sum of | | | (col. 5 ÷ col | | Charges | |
| | | col. 2, 3 and | | 8) | 7) | (col. 6 + col. | | |
| | | 4) | | | | 7) | | |
| | ANCTAL ANY CONTROL COOK OF THE PARTY | 6.00 | 17 | 7.00 | 8.00 | 9.00 | 10.00 | |
| | ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM | 1 | J | 204 220 | 0.0000 | | | |
| | 05100 RECOVERY ROOM | 0 | 2 4 | 1,281,230 | | | 0 | |
| | 05200 DELIVERY ROOM & LABOR ROOM | 0 | | 401,977 | | | 0 | 51.00 |
| | 05300 ANESTHESIOLOGY | 0 | 2 | 026.254 | 0.00000 | | 0 | 52.00 |
| | 05400 RADIOLOGY-DIAGNOSTIC | 0 | 1 | 826,351 | 1 | | 0 | 53.00 |
| | 05600 RADIOISOTOPE | 0 | 1 | 3,736,557 | 1 | | 13,959 | |
| | 06000 LABORATORY | 0 | 1 | 1,047,285 | | | 0 | 56.00 |
| | 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | , 11 | 1,575,735 | | | 33,306 | |
| | 06600 PHYSICAL THERAPY | 0 | ′ , | 225,174 | | | 411 | |
| | 06900 ELECTROCARDIOLOGY | 0 | | 2,617,261 2,285,252 | | | 164,808 | |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | | 1,203,232 1,879,927 | | | 41,946 | 1 |
| | 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | (| 812,107 | | | 1,684 | |
| | 07300 DRUGS CHARGED TO PATIENTS | 0 | 19 | 3,116,681 | | | 0 190.596 | 72.00 |
| | OUTPATIENT SERVICE COST CENTERS | | , 10 | , 110,001 | 0.00000 | 0.000000 | 190,396 | /3.00 |
| | 09000 CLINIC |) | 1 | 789.149 | 0,00000 | 0.000000 | 0 | 90.00 |
| | 09001 SENIOR CARE | 0 | | 492,327 | | | 0 | 90.00 |
| | 09100 EMERGENCY | 0 | 6 | 5,252,196 | | | 0 | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | Ö | | 915.426 | 1 | | 0 | 92.00 |
| 200.00 | | o o | 69 | 254,635 | | 3.000000 | 446,710 | |

| Health Financial Systems | WABASH COUNT | | | In Lie | eu of Form CMS- | 25,52-1 |
|---|--------------------------|------------|---------------|----------------------------|-----------------------------|------------------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S THROUGH COSTS | ERVICE OTHER PASS | | CCN: 151310 | Period: From 01/01/2012 | | _ |
| | | Componen | t CCN: 155365 | то 12/31/2012 | Date/Time Pre 5/29/2013 8:0 | epared: 08 am |
| | | Tit | le XVIII | Skilled Nursing | | |
| AND AND AND AND AND AND AND AND AND AND | | | _ | Facility | 1 | 7 |
| Cost Center Description | Inpatient | Outpatient | Outpatient | PSA Adj. Non | | |
| | Program | Program | Program | | Nursing School | |
| | Pass-Through | Charges | Pass-Through | | | |
| | Costs (col. 8 x col. 10) | | Costs (col. | 9 Cost | | |
| | 11.00 | 12.00 | x col. 12) | 21.00 | 22.00 | - |
| ANCILLARY SERVICE COST CENTERS | 11.00 | 12.00 | 13.00 | 21.00 | 22.00 | ļ |
| 50.00 05000 OPERATING ROOM | 0 | | 1 | | 0 | 50.00 |
| 51.00 05100 RECOVERY ROOM | , ŏ | č | ń | | | 51.0 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | ŏ | Č | S. | 0 | | 52.00 |
| 53.00 05300 ANESTHESIOLOGY | o | Č | Ś | 0 | | 53.00 |
| 54.00 05400 RADIOLOGY-DIAGNOSTIC | 0 | Č | ó | 0 | | 54.00 |
| 56.00 05600 RADIOISOTOPE | 0 | Č | | 0 | | 56.0 |
| 60.00 06000 LABORATORY | 0 | Č | | o o | | 60.0 |
| 63.00 06300 BLOOD STORING, PROCESSING & TRANS. | o | Č | | 0 | , i | 63.0 |
| 66.00 06600 PHYSICAL THERAPY | o | Č | | o o | i o | 66.0 |
| 69.00 06900 ELECTROCARDIOLOGY | 0 | Ċ | | ol o | i o | |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | C | | ol o | i i | |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | C | | ol o | o | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | C | | o | o | |
| OUTPATIENT SERVICE COST CENTERS | | | | | | 1 |
| 90.00 09000 CLINIC | 0 | C | | 0 0 | 0 | 90.00 |
| 90.01 09001 SENIOR CARE | 0 | C |) | 0 | 0 | 90.0 |
| 91.00 09100 EMERGENCY | 0 | C | o | 0 | 0 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | C | | 0 | 0 | 92.00 |
| 200.00 Total (lines 50-199) | 0 | 0 |) | 0 | 0 | 200.0 |

| Health Financial Systems | WABASH COUNT | | | In Lie | u of Form CMS-2552-10 |
|---|---------------------------|---|---------------------------------|--|--|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SI THROUGH COSTS | ERVICE OTHER PAS | Componer | r CCN: 151310 nt CCN: 155365 | | Worksheet D Part IV Date/Time Prepared: 5/29/2013 8:08 am |
| | | Tit | le XVIII | Skilled Nursing Facility | PPS |
| Cost Center Description | PSA Adj. Allied Health | PSA Adj. All Other Medica Education Cos | 1 | | |
| | 23.00 | 24.00 | | The second secon | |
| ANCILLARY SERVICE COST CENTERS | | T | | Photos or 1 a Production of the Contract of th | |
| 50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM | | | 0 | | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | | | 0 | | 51.00 |
| 53.00 05300 ANESTHESIOLOGY | | | 0 | | 52.00 |
| 54.00 05400 RADIOLOGY-DIAGNOSTIC | | | 0 | | 53.00 |
| 56.00 05600 RADIOISOTOPE | U U | | 0 | | 54.00 |
| 60.00 06000 LABORATORY | | | 0 | | 56.00 |
| 63.00 06300 BLOOD STORING, PROCESSING & TRANS. | | | 0 | | 60.00 |
| 66.00 06600 PHYSICAL THERAPY | | | 0 | | 63.00 |
| 69.00 06900 ELECTROCARDIOLOGY | 1 | | 0 | | 69.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | , and a | | ก | | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | i o | | 0 | | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | o o | | Ö | | 73.00 |
| OUTPATIENT SERVICE COST CENTERS | | · | <u> </u> | 7 - 7 - 00 - 100 - | |
| 90.00 09000 CLINIC | | | 0 | The state of the s | 90.00 |
| 90.01 09001 SENIOR CARE | 0 | | 0 | | 90.01 |
| 91.00 09100 EMERGENCY | 0 | | 0 | | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | | 0 | | 92.00 |
| 200.00 Total (lines 50-199) | 0 | | 0 | | 200.00 |

| Health Financial Systems | S | WABASH COUNT | Y HOSPITAL | | In Lie | u of Form CMS- | 2552-10 |
|---|-------------------------|---|---|--|---|-------------------------------|-----------------------------------|
| APPORTIONMENT OF INPATI | ENT ROUTINE SERVICE CAP | ITAL COSTS | Provider | F | Period: From 01/01/2012 To 12/31/2012 | | pared: |
| | | | Tit | le XIX | Hospital | PPS | <u> </u> |
| Cost Center | Description | Capital Related Cost (from Wkst. B, Part II, col. 26) | Swing Bed Adjustment | Reduced Capital Related Cost (col. 1 - col. 2) | | Per Diem (col. 3 / col. 4) | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | SERVICE COST CENTERS | | | | | | |
| 30.00 ADULTS & PEDIATRI | ICS | 103,983 | 7,025 | 96,958 | 2,557 | 37.92 | 30.00 |
| 43.00 NURSERY | | 0 | | (| 0 | 0.00 | 43.00 |
| 44.00 SKILLED NURSING F | | 66,838 | | 66,838 | 4,205 | 15.89 | 44.00 |
| 200.00 Total (lines 30-1 | 199) | 170,821 | | 163,796 | 6,762 | | 200.00 |
| Cost Center | Description | Inpatient Program days | Inpatient Program Capital Cost (col. 5 x col. 6) 7.00 | | | | |
| INPATIENT ROUTINE | SERVICE COST CENTERS | | | | | | |
| 30.00 ADULTS & PEDIATRI 43.00 NURSERY 44.00 SKILLED NURSING F 200.00 Total (lines 30-1 | CCS FACILITY | 64 0 0 64 | 0 | | | | 30.00 43.00 44.00 200.00 |

| APPORT | Financial Systems TIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT | WABASH COUNT | | r CCN: 151310 | Period: | u of Form CMS- Worksheet D | |
|--------------|---|----------------|-----------|---|-----------------|-------------------------------|----------------|
| 7 ti 1 Oit i | TOWNER OF THE ATTENT ANGIETARY SERVICE CAFT | AL COSTS | Frovide | CCN. 131310 | From 01/01/2012 | | |
| | | | | | To 12/31/2012 | | pared: 8 am |
| | | | | tle XIX | Hospital | PPS | |
| | Cost Center Description | Capital | | s Ratio of Cos | 1 7 | Capital Costs | ĺ |
| | | Related Cost | | | | (column 3 x | l |
| | | (from Wkst. B, | | (col. 1 ÷ co | 1. Charges | column 4) | |
| | | Part II, col. | 8) | 2) | | | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | ANCILLARY SERVICE COST CENTERS | - La | | Pital Territoria come montro constituidade en establisha de la come en | | | |
| 50.00 | 05000 OPERATING ROOM | 180,894 | 4,281,23 | 0 0.0422 | 24,692 | 1,043 | 50.00 |
| 51.00 | 05100 RECOVERY ROOM | 6,506 | 401,97 | 7 0.0161 | | | 51.00 |
| | 05200 DELIVERY ROOM & LABOR ROOM | 0 | , | 0.0000 | | 0 | 52.00 |
| | 05300 ANESTHESIOLOGY | 2,488 | 826,35 | 0.0030 | 4,845 | 15 | 53.00 |
| 54.00 | 05400 RADIOLOGY-DIAGNOSTIC | 225,361 | 13,736,55 | 7 0.0164 | 34,129 | 560 | 54.00 |
| | 05600 RADIOISOTOPE | 2,556 | 1,047,28 | 0.0024 | 41 0 | 0 | 56.00 |
| | 06000 LABORATORY | 64,369 | 11,575,73 | 0.0055 | 61 49,879 | 277 | 60.00 |
| | 06300 BLOOD STORING, PROCESSING & TRANS. | 745 | 225,17 | 0.0033 | 09 123 | 0 | 63.00 |
| | 06600 PHYSICAL THERAPY | 22,949 | | 0.0087 | 6,704 | 59 | 66.00 |
| | 06900 ELECTROCARDIOLOGY | 25,863 | _,,_ | | 17 30,576 | 346 | 69.00 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 44,165 | , , | 1 | , | 1,091 | 71.00 |
| | 07200 IMPL. DEV. CHARGED TO PATIENT | 1,130 | , | 1 | 91 0 | 0 | 72.00 |
| | 07300 DRUGS CHARGED TO PATIENTS | 44,898 | 18,116,68 | 0.0024 | 78 117,941 | 292 | 73.00 |
| | OUTPATIENT SERVICE COST CENTERS | | | <u> </u> | | |] |
| | 09000 CLINIC | 17,783 | , . | | | 0 | 20.00 |
| | 09001 SENIOR CARE 09100 EMERGENCY | 14,576 | , | | | 0 | 90.01 |
| | | 47,171 | , , | | , | 125 | 91.00 |
| 200.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 11,875 | , | | - 1 | 0 | 92.00 |
| 200.00 | Total (lines 50-199) | 713,329 | 69,254,63 | 5 | 409,888 | 3,871 | 200.00 |

| APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER | R PASS THROUGH COS | TS Provider | CCN: 151310 | Period: | Worksheet D | |
|--|--|----------------|---------------|--|----------------|--------------|
| | | | | From 01/01/2012 | | |
| | | | | To 12/31/2012 | | |
| | | | | | 5/29/2013 8:0 | 08 am |
| | | | le XIX | Hospital Hospital | PPS | 7 |
| Cost Center Description | Nursing School | Allied Health | | Swing-Bed | Total Costs | |
| | | Cost | Medical | Adjustment | (sum of cols. | 1 |
| | | | Education Cos | | 1 through 3, | |
| | | | | instructions) | minus col. 4) | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | The Tree objections are accommon to the commence of the commen | | * | | | |
| 30.00 03000 ADULTS & PEDIATRICS | 0 | d c | | 0 | C | 30.00 |
| 43.00 04300 NURSERY | 0 | 0 |) | 0 | l | 43.00 |
| 44.00 04400 SKILLED NURSING FACILITY | 0 | . 0 | | 0 | C | 44.00 |
| 200.00 Total (lines 30-199) | 0 | 0 |) | 0 | l | 200.00 |
| Cost Center Description | Total Patient | Per Diem (col. | Inpatient | Inpatient | PSA Adi. | |
| | Days | 5 ÷ col. 6) | Program Days | Program | Nursing School | 1 |
| | | · | • | Pass-Through | | 1 |
| | | | | Cost (col. 7 x | | |
| | | | | col. 8) | | |
| | 6.00 | 7.00 | 8.00 | 9.00 | 11.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 03000 ADULTS & PEDIATRICS | 2,557 | 0.00 | 6 | 4 0 | 0 | 30.00 |
| 43.00 04300 NURSERY | 0 | 0.00 | 1 | ol o | ĺ | |
| 44.00 04400 SKILLED NURSING FACILITY | 4,205 | 0.00 |) | o o | ĺ | |
| 200.00 Total (lines 30-199) | 6,762 | 1 | 6 | 4 o | , | 200.00 |
| Cost Center Description | PSA Adi. | PSA Adi. All | | <u>' </u> | | 200.00 |
| · | | Other Medical | 1 | | | |
| | Cost | Education Cost | | | | |
| | 12.00 | 13.00 | | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 03000 ADULTS & PEDIATRICS | 0 | 0 | | | | 30.00 |
| 43.00 04300 NURSERY | n | ň | | | | 43.00 |
| 44.00 04400 SKILLED NURSING FACILITY | ň | ň | | | | 44.00 |
| 200.00 Total (lines 30-199) | 0 | 0 | | | | |
| () () () () () () () () () () | 1 0 | ι . υ | 1 | | | 200.0 |

| | Financial Systems | WABASH COUN | | | | | u of Form CMS- | 2552-10 |
|--------|---|-----------------|-------|-----------|---------------|---|----------------|------------------|
| | TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE SH COSTS | RVICE OTHER PAS | SS | | | Period: From 01/01/2012 To 12/31/2012 | | pared: 08 am_ |
| | A - 1-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0 | | | | le XIX | Hospital | PPS | |
| | Cost Center Description | | Nursi | ng School | Allied Health | | Total Cost | |
| | | Anesthetist | | | | Medical | (sum of col 1 | |
| | | Cost | | | | Education Cost | | |
| | | 1.00 | | 2.00 | 3.00 | 4.00 | 4) 5.00 | |
| | ANCILLARY SERVICE COST CENTERS | | | | J. 00 | 1 4.00 | 1.00 | |
| 50.00 | 05000 OPERATING ROOM | (| | 0 | | 0 0 | 0 | 50.00 |
| 51.00 | 05100 RECOVERY ROOM | | 5 | ō | | o o | , o | 51.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | | 5 | 0 | | ol o | l o | 52.00 |
| 53.00 | 05300 ANESTHESIOLOGY | | ol | 0 | | o o | l ŏ | 53.00 |
| 54.00 | 05400 RADIOLOGY-DIAGNOSTIC | | ol | 0 | | o o | ľ | 54.00 |
| 56.00 | 05600 RADIOISOTOPE | |) | 0 | 4 | 0 | ا م | 56.00 |
| 60.00 | 06000 LABORATORY | | o | 0 | | o o | ő | 60.00 |
| 63.00 | 06300 BLOOD STORING, PROCESSING & TRANS. | | o | 0 | | o o | Ö | 63.00 |
| | 06600 PHYSICAL THERAPY | | o | 0 | | o o | ŏ | 66.00 |
| 69.00 | 06900 ELECTROCARDIOLOGY | (| o | 0 | | o o | ŏ | 69.00 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | וֹס | 0 | | 0 | ő | 71.00 |
| | 07200 IMPL. DEV. CHARGED TO PATIENT | | o | 0 | | o o | Ō | 72.00 |
| | 07300 DRUGS CHARGED TO PATIENTS | |) | 0 | (| 0 | 0 | 73.00 |
| | OUTPATIENT SERVICE COST CENTERS | | ., | | | | | 1 |
| | 09000 CLINIC | | | 0 | (| 0 | 0 | 90.00 |
| | 09001 SENIOR CARE | (|) | 0 | (| 0 | 0 | 90.01 |
| | 09100 EMERGENCY | |) | 0 | (| 0 | Ō | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | |) | 0 | (| o o | 0 | 92.00 |
| 200.00 | Total (lines 50-199) | |) | 0 | (|) (| 0 | 200.00 |

| | Financial Systems | WABASH COUNT | | | | u of Form CMS- | <u> 2552-10</u> |
|--------|---|-------------------------------|---------------|--|---|--|-----------------|
| | TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE H COSTS | RVICE OTHER PAS | | | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV Date/Time Pre 5/29/2013 8:0 | |
| | | | | tle XIX | Hospital | PPS | |
| | Cost Center Description | Total Outpatient Cost (sum of | (from Wkst. C | Ratio of Cost to Charges (col. 5 ÷ col | Ratio of Cost | Inpatient Program Charges | |
| | | col. 2, 3 and 4) | | 7) | (col. 6 ÷ col. 7) | | |
| | | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| F0 00 | ANCILLARY SERVICE COST CENTERS | | - | | | | |
| | 05000 OPERATING ROOM | 0 | 4,281,230 | | | 24,692 | 1 |
| | 05100 RECOVERY ROOM | 0 | 401,97 | | | 3,893 | |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | (| 0.00000 | | 0 | 52.00 |
| | 05300 ANESTHESIOLOGY | 0 | 826,35 | | | 4,845 | |
| | 05400 RADIOLOGY-DIAGNOSTIC | 0 | 13,736,55 | | | 34,129 | |
| | 05600 RADIOISOTOPE | 0 | 1,047,28 | 1 | | 0 | 56.00 |
| 60.00 | 06000 LABORATORY | 0 | 11,575,73 | | | 49,879 | 1 |
| 63.00 | 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | 225,17 | | | 123 | |
| 66.00 | 06600 PHYSICAL THERAPY | 0 | 2,617,26 | | | 6,704 | |
| 69.00 | 06900 ELECTROCARDIOLOGY | 0 | 2,285,25 | | | 30,576 | |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 4,879,92 | 1 | | 120,579 | |
| | 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 812,10 | | | 0 | |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS | 0 | 18,116,68 | 0.00000 | 0.000000 | 117,941 | 73.00 |
| 90.00 | 09000 CLINIC | T | 700 14 | 0.0000 | 0 000000 | | |
| | 09001 SENIOR CARE | | 789,149 | | | 0 | 90.00 |
| | 09100 EMERGENCY | | 492,327 | | | 0 | 90.01 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | 6,252,190 | | | 16,527 | 1 |
| 200.00 | | 0 | 915,426 | | 0.000000 | 0 | 92.00 |
| 200.00 | | 1 0 | 69,254,635 |) | 1 | 409.888 | 1200.00 |

| Health | Financial Systems | WABASH COUNT | Y HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|--------|--|--|------------|--------------|---|-----------------|----------------|
| | TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE H COSTS | RVICE OTHER PASS | | CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | | pared: 8 am |
| | | - representation of the representation of th | Tit | le XIX | Hospital | PPS | |
| | Cost Center Description | Inpatient | Outpatient | Outpatient | PSA Adj. Non | PSA Adj. | |
| | | Program | Program | Program | | Nursing School | |
| | | Pass-Through | Charges | Pass-Through | | | |
| | | Costs (col. 8 | | Costs (col. | 9 Cost | | |
| | | x col. 10) | | x col. 12) | | | |
| | | 11.00 | 12.00 | 13.00 | 21.00 | 22.00 | |
| FO 00 | ANCILLARY SERVICE COST CENTERS | | | · | | | |
| | 05000 OPERATING ROOM | 0 | 0 | | 0 | 0 | 50.00 |
| | 05100 RECOVERY ROOM | 0 | 0 | | 0 | 0 | 51.00 |
| | 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | | 0 | 0 | 52.00 |
| 53.00 | 05300 ANESTHESIOLOGY | 0 | 0 | | 0 | 0 | 53.00 |
| 54.00 | 05400 RADIOLOGY-DIAGNOSTIC | 0 | 0 | | 0 | 0 | 54.00 |
| 56.00 | 05600 RADIOISOTOPE | 0 | 0 | | 0 | 0 | 56.00 |
| 60.00 | 06000 LABORATORY | 0 | 0 | | 0 | 0 | 60.00 |
| 63.00 | 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | 0 | | 0 | 0 | 63.00 |
| 66.00 | 06600 PHYSICAL THERAPY | 0 | 0 | | 0 0 | 0 | 66.00 |
| 69.00 | 06900 ELECTROCARDIOLOGY | 0 | 0 | | 0 | 0 | 69.00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | 0 | 0 | 71.00 |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 0 | | 0 | 0 | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | _0 | 0 | | 0 0 | 0 | 73.00 |
| | OUTPATIENT SERVICE COST CENTERS | ., | | | | | |
| | 09000 CLINIC | 0 | 0 | | 0 0 | 0 | 90.00 |
| 90.01 | 09001 SENIOR CARE | 0 | 0 | | 0 0 | 0 | 90.01 |
| 91.00 | 09100 EMERGENCY | 0 | 0 | | 0 | 0 | 91.00 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 0 | | 0 | 0 | 92.00 |
| 200.00 | Total (lines 50-199) | 0 | 0 | 1 | 0 | 0 | 200.00 |

| THROUGH COSTS | | INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 151: | | | Period: From 01/01/2012 To 12/31/2012 | of Form CMS Worksheet D Part IV Date/Time Pr 5/29/2013 8: | epared: | |
|---------------|--|--|--------------------|-------------------|---|--|-------------|---------|
| | Cost Center Description | PSA Adj. Allied Health | PSA Adj Other M | j. All Medical | le XIX | Hospital | PPS | |
| | | 23.00 | 24. | | | | | |
| | ANCILLARY SERVICE COST CENTERS | | | | Annual Marie Margarit en 1994 principal mentida annual francisco n <u>u</u> m | | | |
| | 05000 OPERATING ROOM | 0 | | 0 | | The second secon | | 50.00 |
| | 05100 RECOVERY ROOM | 0 | | 0 | | | | 51.00 |
| 52.00 | The state of the s | 0 | 1 | 0 | | | | 52.00 |
| 53.00 | 05300 ANESTHESIOLOGY | 0 | | 0 | | | | 53.00 |
| 54.00 | 05400 RADIOLOGY-DIAGNOSTIC | 0 | | 0 | | | | 54.00 |
| 56.00 | 05600 RADIOISOTOPE | 0 | İ | 0 | | | | 56.00 |
| 60.00 | 06000 LABORATORY | 0 | | 0 | | | | 60.00 |
| 63.00 | 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | | 0 | | | | 63.00 |
| 66.00 | 06600 PHYSICAL THERAPY | 0 | i | 0 | | | | 66.00 |
| 69.00 | 06900 ELECTROCARDIOLOGY | 0 | | 0 | | | | 69.00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | | 0 | | | | 71.00 |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | | 0 | | | | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | | 0 | | | | 73.00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | - /3.00 |
| 90.00 | 09000 CLINIC | 0 | | 0 | | | | 90.00 |
| | 09001 SENIOR CARE | 0 | | 0 | | | | 90.00 |
| | 09100 EMERGENCY | o | | ō | | | | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | | 0 | | | | 92.00 |
| 200.00 | | 0 | | 0 | | | | 200.00 |

| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN | ND VACCINE COST | COST Provider CCN: 151310 Period: From 01/01/2012 To 12/31/2012 | | | | |
|---|---|---|-----------------|---------------|--|--------|
| | | Tit | le XIX | Hospital | PPS | |
| | | | Charges | | Costs | |
| Cost Center Description | | PPS Reimbursed | Reimbursed Cost | | PPS Services | |
| | | Services (see | Reimbursed | Reimbursed | (see inst.) | |
| | Worksheet C, | inst.) | Services | Services Not | | |
| | Part I, col. 9 |) | Subject To | Subject To | | |
| | | | | Ded. & Coins. | | l |
| | · Branch Comments of the Comment of | | (see inst.) | (see inst.) | | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| ANCILLARY SERVICE COST CENTERS | | | * | | The state of the s | |
| 50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM | 0.549349 | _ | | 0 226,514 | 0 | |
| | 0.393709 | _ | | 0 32,424 | 0 | |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0.000000 | 1 | | 0 | 0 | 52.0 |
| 53.00 05300 ANESTHESIOLOGY | 0.127055 | | | 48,638 | 0 | |
| 54.00 05400 RADIOLOGY-DIAGNOSTIC | 0.226566 | | | 0 1,144,409 | 0 | 54.0 |
| 56.00 05600 RADIOISOTOPE | 0.268751 | - | | 0 48,338 | 0 | 56.0 |
| 60.00 06000 LABORATORY | 0.234749 | | | 0 854,461 | 0 | 60.0 |
| 63.00 06300 BLOOD STORING, PROCESSING & TRANS. | 0.584321 | | | 0 1,233 | 0 | 63.0 |
| 66.00 06600 PHYSICAL THERAPY | 0.647872 | _ | | 0 97,291 | 0 | 66.0 |
| 69.00 06900 ELECTROCARDIOLOGY | 0.451042 | 1 | | 0 53,767 | 0 | 69.0 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0.486559 | _ | | 0 247,366 | 0 | 71.0 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 0.208725 | | | 0 | 0 | 72.0 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0.202467 | 0 | | 0 850,026 | 0 | 73.00 |
| OUTPATIENT SERVICE COST CENTERS | | | · | | | |
| 90.00 09000 CLINIC | 0.341308 | _ | | 0 65,318 | 0 | 90.00 |
| 90.01 09001 SENIOR CARE | 0.836684 | - | | 0 0 | 0 | 90.0 |
| 91.00 09100 EMERGENCY | 0.449904 | | | 1,137,700 | 0 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0.388444 | 0 | | 28,624 | 0 | 92.00 |
| Subtotal (see instructions) | | 0 | | 4,836,109 | | 200.00 |
| 201.00 Less PBP Clinic Lab. Services-Program | | | | 0 | | 201.0 |
| Only Charges | | | | | | |
| 202.00 Net Charges (line 200 +/- line 201) | | 0 | | 0 4,836,109 | 0 | 202.0 |

0

1,541,972

201.00

202.00

201.00

202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 +/- line 201)

Only Charges

| | Financial Systems WABASH COUNTY HO FATION OF INPATIENT OPERATING COST | Provider CCN: 151310 | Period: | u of Form CMS- Worksheet D-1 | |
|----------------|---|------------------------------------|----------------------------------|-----------------------------------|---------|
| | | | From 01/01/2012 To 12/31/2012 | Date/Time Pre 5/29/2013 8:0 | |
| | Cost Caston Decembring | Title XVIII | Hospital | Cost | 70 alli |
| | Cost Center Description | | | 1,00 | |
| | PART I - ALL PROVIDER COMPONENTS | | | | |
| 1.00 | INPATIENT DAYS Inpatient days (including private room days and swing-bed days, | excluding newborn) | | 2 902 | 1 0 |
| 2.00 | Inpatient days (including private room days, excluding swing-be | ed and newborn days) | | 2,802 2,557 | |
| 3.00 | Private room days (excluding swing-bed and observation bed days | s). If you have only pr | ivate room days, | 0 | |
| 4.00 | do not complete this line. Semi-private room days (excluding swing-bed and observation bed | 4. 4> | | | |
| 5.00 | Total swing-bed SNF type inpatient days (including private room | 1 days) n days) through Decembe | r 31 of the cost | 2,265 178 | 4 |
| | reporting period | | | 176 |] 3.0 |
| 6.00 | Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line) | n days) after December | 31 of the cost | 0 | 6.0 |
| 7.00 | Total swing-bed NF type inpatient days (including private room | days) through Docombon | 31 of the cost | 67 | 7.0 |
| | reporting period | | | 67 | 7.0 |
| 8.00 | Total swing-bed NF type inpatient days (including private room | days) after December 3 | 1 of the cost | 0 | 8.0 |
| 9.00 | reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to | the Program Caveludina | and an in-d | 1 202 | |
| | newborn days) | | | 1,202 | 9.00 |
| 10.00 | Swing-bed SNF type inpatient days applicable to title XVIII onl | ly (including private r | oom days) | 178 | 10.0 |
| 11.00 | through December 31 of the cost reporting period (see instructi Swing-bed SNF type inpatient days applicable to title XVIII onl | ions) | | | |
| 11.00 | December 31 of the cost reporting period (if calendar year, ent | er 0 on this line) | | 0 | 11.0 |
| 12.00 | Swing-bed NF type inpatient days applicable to titles v or XTX | only (including privat | e room days) | 0 | 12.0 |
| 13.00 | through December 31 of the cost reporting period | | | | |
| 13.00 | Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar yea | Only (including privat | e room days) | 0 | 13.0 |
| 14.00 | Medically necessary private room days applicable to the Program | n (excluding swing-bed | days) | 0 | 14.0 |
| 15.00 | Total nursery days (title V or XIX only) | | | 0 | |
| 16.00 | Nursery days (title V or XIX only) SWING BED ADJUSTMENT | | | 0 | 16.0 |
| 17.00 | Medicare rate for swing-bed SNF services applicable to services | through December 31 o | f the cost | | 17.00 |
| | reporting period | | | | 17.00 |
| 18.00 | Medicare rate for swing-bed SNF services applicable to services reporting period | after December 31 of | the cost | | 18.0 |
| 19.00 | Medicaid rate for swing-bed NF services applicable to services | through December 31 of | the cost | 132.00 | 10.00 |
| | reporting period | | | 132.00 | 19.00 |
| 20.00 | Medicaid rate for swing-bed NF services applicable to services reporting period | after December 31 of t | he cost | 132.00 | 20.00 |
| 21.00 | Total general inpatient routine service cost (see instructions) | | | 3,339,461 | 21 0 |
| 22.00 | Swing-bed cost applicable to SNF type services through December | 31 of the cost report | ing period (line | 3,339,461 | 22.00 |
| 23.00 | 5 X 11ne 1/) | | | | |
| 23.00 | Swing-bed cost applicable to SNF type services after December 3×1 line $18)$ | 1 of the cost reportin | g period (line 6 | 0 | 23.00 |
| 24.00 | Swing-bed cost applicable to NF type services through December | 31 of the cost reporti | ng period (line | 8 844 | 24.00 |
| 25 00 | / X line 19) | | | 0,044 | 24.00 |
| 23.00 | Swing-bed cost applicable to NF type services after December 31 x line 20) | of the cost reporting | period (line 8 | 0 | 25.00 |
| 26.00 | Total swing-bed cost (see instructions) | | | 225,609 | 26.00 |
| 27.00 | General inpatient routine service cost net of swing-bed cost (1 | ine 21 minus line 26) | | 3,113,852 | |
| 28.00 | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed | | | | |
| 29.00 | Private room charges (excluding swing-bed charges) | cnarges) | | 4,988,845 | |
| 30.00 | Semi-private room charges (excluding swing-bed charges) | | | 0 4,988,845 | |
| 31.00 | General inpatient routine service cost/charge ratio (line 27 - | line 28) | | 0.624163 | 31.00 |
| 32.00 33.00 | Average private room per diem charge (line 29 ÷ line 3) | | | | 32.00 |
| 34.00 | Average semi-private room per diem charge (line 30 ÷ line 4) | | | 2,202.58 | |
| 35.00 | Average per diem private room charge differential (line 32 minu | s line 33)(see instruct | tions) | 0.00 | |
| 36.00 | Average per diem private room cost differential (line 34×1 line Private room cost differential adjustment (line 3×1 line 35) | 31) | | 0.00 | 35.00 |
| 37.00 | General inpatient routine service cost net of swing-bed cost and | d nadusta man and di | 56 | 0 | 36.00 |
| | 27 minus Tine 30) | u private room COST dii | rerential (line | 3,113,852 | 37.00 |
| | PART II - HOSPITAL AND SUBPROVIDERS ONLY | | | | |
| 38.00 | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST | IMENTS | | | |
| 39.00 | Adjusted general inpatient routine service cost per diem (see i Program general inpatient routine service cost (line 9 x line 3 | nstructions) %\ | | 1,217.78 | |
| 10.00 | Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 + | (line 14 v line 35) | | 1,463,772 | |
| | | | | 0 | 40.00 |

| MPUI | ATION OF INPATIENT OPERATING COST | | | Provider | CCN: 151310 | Period: | Worksheet D-1 | 2552-1 |
|----------------|--|---|-----------------|------------------------|------------------------|----------------------------------|--------------------------|--------------|
| | | | | | | From 01/01/2012 To 12/31/2012 | Date/Time Pre | |
| | | | | T-1+1 | e XVIII | | 5/29/2013 8:0 | |
| | Cost Center Description | Total | Ţ! | Total | e xviii Average Per | Hospital Program Days | Cost Program Cost | T |
| | · · · · · · · · · · · · · · · · · · · | Inpatient Cost | | | Diem (col. 1 | | (col. 3 x col. | |
| | | 1.00 | | 2.00 | col. 2) 3.00 | 4.00 | 4) | |
| .00 | NURSERY (title V & XIX only) | 1.00 | | 2.00 | | 4.00 | 5.00 | 42.0 |
| | Intensive Care Type Inpatient Hospital Units | | - | | | | | 12.0 |
| | INTENSIVE CARE UNIT CORONARY CARE UNIT | | | | | | | 43.0 |
| | BURN INTENSIVE CARE UNIT | | | | | | | 44.0 |
| .00 | SURGICAL INTENSIVE CARE UNIT | | | | | | | 46.0 |
| .00 | OTHER SPECIAL CARE (SPECIFY) | | | | | | | 47.0 |
| | Cost Center Description | | | | | | 1 00 | |
| .00 | Program inpatient ancillary service cost (Wks | st. D-3, col. | 3, 1ir | ne 200) | | ···· | $\frac{1.00}{1,449,870}$ | 48.0 |
| .00 | Total Program inpatient costs (sum of lines | 11 through 48) | (see | instructio | ns) | | 2,913,642 | |
| .00 | PASS THROUGH COST ADJUSTMENTS | | | | | | | |
| .00 | Pass through costs applicable to Program inpa | atient routine | serv | ices (from | Wkst. D, sur | n of Parts I and | 0 | 50.0 |
| .00 | Pass through costs applicable to Program inpa | atient ancilla | ry sei | rvices (fr | om Wkst. D, s | sum of Parts II | o | 51.0 |
| - 1 | and IV) | | | | • | _ | | |
| .00 | Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclud | ov and 51) Hing capital m | alator | d non-nhu | sician anas+l | natist and | 0 | 52.0 |
| Į. | medical education costs (line 49 minus line ! | 52) | | a, non-pity | arcian anestr | iecist, and | 0 | 53.0 |
| ľ | TARGET AMOUNT AND LIMIT COMPUTATION Program discharges | 7 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 | | | | | | |
| | Target amount per discharge | | | | | | 0 00 | 54.0 |
| 00 | Target amount (line 54 x line 55) | | | | | | 0.00 | 55. 56. |
| 00 | Difference between adjusted inpatient operat | ing cost and ta | arget | amount (1 | ine 56 minus | line 53) | ő | 57. |
| 00 | Bonus payment (see instructions) | | | | | | 0 | 58. |
| " | Lesser of lines 53/54 or 55 from the cost repmarket basket | orting period | endir | 1g 1996, u | pdated and co | ompounded by the | 0.00 | 59. |
| 00 | Lesser of lines 53/54 or 55 from prior year of | ost report, up | odated | d by the m | arket basket | - | 0.00 | 60. |
| 00 | If line 53/54 is less than the lower of lines | 55. 59 or 60 | enter | the less | er of 50% of | the amount by | 0 | 61. |
| - 1 | which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see | nexpected cost | ts (Ti | ines 54 x | 60), or 1% of | f the target | | |
| 00 | Relief payment (see instructions) | | | | | | 0 | 62.0 |
| 00 | Allowable Inpatient cost plus incentive payme | nt (see instru | uction | ıs) | | | | 63.0 |
| 00 | PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost | s through Doce | mhor | 21 of the | cost nanonti | ng paried (See | 216 765 | . |
| ! | instructions)(title XVIII only) | | | | | | 216,765 | 64.0 |
| 00 | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) | s after Decemb | oer 31 | of the c | ost reporting | period (See | o | 65.0 |
| 00 | Total Medicare swing-bed SNF inpatient routing | a costs (line | 64 n] | luc lino 6 | E)/+i+1a M/TT | T amily) Fam | 246 765 | |
| - 1 | CAH (See instructions) | | | | | | 216,765 | 66.0 |
| 00 | Title V or XIX swing-bed NF inpatient routine | costs through | Dece | ember 31 o | f the cost re | porting period | o | 67.0 |
| | (line 12 x line 19) Title V or XIX swing-bed NE inpationt routing | costs often D | | | - | | _ | |
| 1 | Title V or XIX swing-bed NF inpatient routine (line 13 x line 20) | | | | | orting period | 0 | 68.0 |
| 00 | Total title V or XIX swing-bed NF inpatient r | outine costs (| [line_ | 67 + line | 68) | | 0 | 69.0 |
| 00 | PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili | RSING FACILITY | , AND | ICF/MR O | ILY | | | |
| 00 1 | Adjusted general inpatient routine service co | st per diem (1 | ine s line 7 | ervice co 'O ∸ line | St (11ne 3/) 2) | | | 70.0 |
| 00 | Program routine service cost (line 9 x line 7 | 1) | | | | | | 71.0 72.0 |
| 00 1 | Medically necessary private room cost applica | ble to Program | ı (lin | e 14 x li | ne 35) | | | 73.0 |
| 00 | Total Program general inpatient routine servi Capital-related cost allocated to inpatient r | ce costs (line | 72 + | line 73) | ankchast a = | loub TT 3 | | 74.0 |
| - 1 | 20, Tine 45) | | CUST | .s CITOM W | orksneet B, P | art II, column | | 75.0 |
| 00 | Per diem capital-related costs (line 75 ÷ lin | e 2) | | | | | | 76.0 |
| 0 | Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus | 76) | | | | | | 77.0 |
|)0 <i>i</i> | Aggregate charges to beneficiaries for excess | costs (from n | rovid | er record | 5) | | | 78.0 |
| 10 | lotal Program routine service costs for compa | rison to the c | ost 1 | imitation | (line 78 min | us line 79) | | 79.0 80.0 |
| , v | inpatient routine service cost per diem limit | ation | | | | | | 81.0 |
| . 00 00 ⊩ | Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s | ne 9 x line 81 | .) | | | | | 82.0 |
| ון טכ | program inpatient ancillary services (see ins | tructions) | | | | | | 83.0 |
| 00 ι | Jtilization review - physician compensation (| see instructio | ns) | | | | | 84.0 85.0 |
| | Total Program inpatient operating costs (sum | of lines 83 th | rough | 85) | | | | 86.0 |
| 00 | | | | | | | | |
| P | ART IV - COMPUTATION OF OBSERVATION BED PASS Total observation hed days (see instructions) | THROUGH COST | | | | | | |
| 00 7 00 4 | Total observation bed days (see instructions) adjusted general inpatient routine cost per dobservation bed cost (line 87 x line 88) (see | iem (line 27 ± | line | 2) | | | 292 1,217.78 | 87.0 |

| | Financial Systems | WABASH COU | NTY HOSPITAL | | In Lie | eu of Form CMS- | 2552-10 |
|-------------------|---|------------|--------------------------------|---------|----------------------------|--|-----------------|
| COMPUT | FATION OF INPATIENT OPERATING COST | | Provider | | Period: From 01/01/2012 | Worksheet D-1 | |
| | | | | | то 12/31/2012 | Date/Time Pre 5/29/2013 8:0 | pared: 08 am |
| | | | Tit] | e XVIII | Hospital | Cost | |
| | Cost Center Description | Cost | Routine Cost (from line 27) | | | (col. 3 x col. 4) (see instructions) | |
| The second second | COMPUTATION OF OBSERVATION BED PASS THROUGH | | 2.00 | 3.00 | 4.00 | 5.00 | |
| 90.00 | Capital-related cost | | 0 0 | 0.00000 | <u> </u> | | 90.00 |
| 91.00 | Nursing School cost | | o o | 0.00000 | 1 | 0 | 91.00 |
| | The nearen cose | | 0 | 0.00000 | | ŏ | 92.00 |
| 93.00 | All other Medical Education | | 0 0 | 0.00000 | 0 0 | 0 | 93.00 |

| OMPU | TATION OF INPATIENT OPERATING COST WABASH COUNTY HO | Provider CCN: 151310 | Period: | u of Form CMS- Worksheet D-1 | |
|------------|---|--|---------------------------------------|---------------------------------|------------|
| | | Component CCN: 155365 | From 01/01/2012 | Date/Time Pre 5/29/2013 8:0 | epare |
| | | Title XVIII | Skilled Nursing Facility | PPS | o all |
| | Cost Center Description | | | 1.00 | |
| | PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS | | | | ļ |
| .00 | Inpatient days (including private room days and swing-bed days | . excluding newborn) | · · · · · · · · · · · · · · · · · · · | 4 205 | |
| .00 | Inpatient days (including private room days, excluding swing-he | ed and newhorn days) | İ | 4,205 4,205 | |
| .00 | Private room days (excluding swing-bed and observation bed days | s). If you have only pr | ivate room days, | 0 | 1 |
| .00 | do not complete this line. Semi-private room days (excluding swing-bed and observation bed | | | | |
| .00 | Total swing-bed SNF type inpatient days (including private room | u days) m days) through Decembe | r 31 of the cost | 4,205 | |
| | preporting period | | 1 | 245 | 5 |
| .00 | Total swing-bed SNF type inpatient days (including private room | m days) after December | 31 of the cost | 0 | 6 |
| .00 | reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room | dayed themough passation | 21 5 1 | | |
| | reporting period | | 1 | 67 | 7 |
| .00 | Total swing-bed NF type inpatient days (including private room | days) after December 33 | l of the cost | 0 | 8 |
| .00 | preporting period (if Calendar Year, enter () on this line) | | | ŭ | |
| . 00 | Total inpatient days including private room days applicable to newborn days) | the Program (excluding | swing-bed and | 835 | 9 |
| 00.0 | Swing-bed SNF type inpatient days applicable to title XVIII on | ly (including private re | nom days) | 178 | 10 |
| .00 | through becember 31 of the Cost reporting period (see instructi | ione) | | 176 | 10 |
| .00 | Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, ent | ly (including private re | oom days) after | 0 | 11 |
| .00 | SWING-Ded NE type inpatient days applicable to titles you viv | ter U on this line) only (including private | room days) | • | |
| | through becember 31 of the Cost reporting period | | | 0 | 12 |
| .00 | Swing-bed NF type inpatient days applicable to titles v or XIX | only (including private | room days) | 0 | 13 |
| .00 | after December 31 of the cost reporting period (if calendar year Medically necessary private room days applicable to the Program | ar, enter 0 on this line | 2) | | |
| 00 | Total nursery days (title V or XIX only) | (excluding swing-bed (| lays) | 0 | _ |
| .00 | Nursery days (title V or XIX only) | | | 0 | |
| 00 | SWING BED ADJUSTMENT | | | | 1 |
| • | Medicare rate for swing-bed SNF services applicable to services reporting period | | 1 | | 17 |
| 00 | Medicare rate for swing-bed SNF services applicable to services | after December 31 of t | he cost | | 18 |
| 00 | reporting period | | | | 10 |
| • | Medicaid rate for swing-bed NF services applicable to services reporting period | | | 132.00 | 19 |
| 00 | Medicaid rate for swing-bed NF services applicable to services | after December 31 of th | e cost | 122.00 | 3.0 |
| 00 | reporting period | | 10 0030 | 132.00 | 20 |
| 00 | Total general inpatient routine service cost (see instructions) | | | 1,671,668 | 21 |
| | Swing-bed cost applicable to SNF type services through December 5×1 line 17) | | | 0 | 22 |
| 00 | Swing-bed cost applicable to SNF type services after December 3 x line 18) | 1 of the cost reporting | neriod (line 6 | 0 | 22 |
| 00 | | | | U | 23 |
| 00 | Swing-bed cost applicable to NF type services through December 7 \times line 19) | 31 of the cost reportin | g period (line | 8,844 | 24 |
| 00 | Swing-bed cost applicable to NF type services after December 31 | of the cost reporting | neriod (line 8 | | 3.5 |
| 00 | | and door reporting | per rou (Trile a | 0 | 25 |
| | Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (1 | | | 100,393 | 26 |
| | LVIANIE KOOM DIELEKENITAL ADJUSTMENT | | | 1,571,275 | 27 |
| 00 | General inpatient routine service charges (excluding swing-hod | charges) | | 1,276,174 | 20 |
| UU | Private room charges (excluding swing-hed charges) | 3, | | 1,2/0,1/4 | 28 29 |
| 00 | Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ | 7.i 202 | | 1,276,174 | 30 |
| 00 | Average private room per diem charge (line 20 ± line 3) | rine 28) | | 1.231239 | |
| JU | Average semi-private room per diem charge (line 30 ± line 4) | | | 0.00 303.49 | |
| UU | Average per glem private room charge differential (line 32 minus | s line 33)(see instruct | ions) | 0.00 | 33 34 |
| - | Average per diem private room cost differential (line 34×1 line Private room cost differential adjustment (line 3×1 line 35) | 31) | | 0.00 | |
| <i>5</i> 0 | General inpatient routine service cost net of swing-had cost and | d private room cost dif | forantial (li- | 0 | 36 |
| | | - P. IVALE TOURI COSE ATT | rerential (Inne | 1,571,275 | 37 |
| | PART II - HOSPITAL AND SUBPROVIDERS ONLY | | | | |
| , | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST Adjusted general inpatient routine service cost per diem (see in | | | | |
| , , | ''' vg' am general impatient routine service cost (line a v line o | 2) | İ | | 38 |
| <i>,</i> | Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 + | (72 14 2: 20) | | | 39. 40. |
| າດໍ | | | | | |

| | TATION OF INPATIENT OPERATING COST | | Pr | TAL ovider | | Period: | Worksheet D-1 | 255 L |
|--|--|--|--|---|--|--|--|--|
| | | | | | | From 01/01/2012 To 12/31/2012 | Date/Time Pre | epar |
| | | | | Titl | e XVIII | Skilled Nursing | 5/29/2013 8:0 PPS |)8 a |
| | | | | 1101 | CATIL | Facility | PFS | |
| | Cost Center Description | Total Inpatient Cos | Tot stInpatie | | Average Per Diem (col. 1 | Program Days | Program Cost (col. 3 x col. | |
| | | 1.00 | 2.0 | 00 | col. 2) 3.00 | 4.00 | 5.00 | - |
| 2.00 | NURSERY (title V & XIX only) | | | | | | 5,00 | 4 |
| 2 00 | Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT | ļ | | | | | |] |
| | CORONARY CARE UNIT | | | | | | | 4 |
| | BURN INTENSIVE CARE UNIT | | | | | | | 4 |
| 5.00 | SURGICAL INTENSIVE CARE UNIT | | | | | | | 4 |
| .00 | OTHER SPECIAL CARE (SPECIFY) | | | | | | | 4 |
| | Cost Center Description | | | | | | | |
| .00 | Program inpatient ancillary service cost (wk | r+ D 2 col | 2 1: | 2003 | | resource with the first section desired to the section of the sect | 1.00 | 1 |
| .00 | Total Program inpatient costs (sum of lines | SC. D-3, COI. 41 through 48 | 3, Tine . | 200) tructio | ne) | | | 4 |
| | PASS THROUGH COST ADJUSTMENTS | | | | | | | 4 |
| .00 | The same of the sa | atient routin | e service | s (from | Wkst. D, sum | of Parts I and | | 5 |
| .00 | III) | | | | | | | |
| | Pass through costs applicable to Program inpland IV) | | ary servi | ces (fr | om Wkst. D, s | um of Parts II | | 5 |
| .00 | Total Program excludable cost (sum of lines | 50 and 51) | | | | | | 5 |
| .00 | Total Program inpatient operating cost exclude | ding capital | related, | non-phy | sician anesth | etist, and | | 5 |
| | medical education costs (line 49 minus line : TARGET AMOUNT AND LIMIT COMPUTATION | 52) | | | | | . <u></u> | 1 |
| .00 | Program discharges | | | | THE STATE OF THE S | | | _ ا |
| .00 | Target amount per discharge | | | | | | | 5 |
| .00 | Target amount (line 54 x line 55) | | | | | | | 5 |
| .00 | Difference between adjusted inpatient operat | ing cost and t | target am | ount (1 | ine 56 minus | line 53) | | 5 |
| .00 | The property of the control of the c | aantina maui. | والمستران المستران | 1006 | | | | 5 |
| .00 | market basket | porting perior | a enaing . | 1996, и | pdated and co | mpounded by the | | 5 |
| .00 | Lesser of lines 53/54 or 55 from prior year | cost report, i | updated by | y the m | arket basket | | | 60 |
| 00 | IT line 53/54 is less than the lower of lines | s 55. 59 or 60 | O enter ti | he less | er of 50% of | the amount by | | 6: |
| | which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see | expected cos | sts (lines | s 54 x | 60), or 1% of | the target | | |
| .00 | Relief payment (see instructions) | instructions) | | | | | | |
| .00 | Allowable Inpatient cost plus incentive payme | ent (see insti | ructions) | | | | | 6 |
| | PROGRAM INPATIENT ROUTINE SWING BED COST | | | | | | | 1 6 |
| 00 | Modisons swimm had sur in the | | | | | | | 6. |
| .00 | Medicare swing-bed SNF inpatient routine cost | s through Dec | cember 31 | of the | cost reporti | ng period (See | | |
| | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost | | | | | | | 6. |
| .00 | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) | s after Decem | mber 31 of | f the c | ost reporting | period (See | | 64 |
| .00 | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine | s after Decem | mber 31 of | f the c | ost reporting | period (See | | 64 65 |
| .00 | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine CAH (see instructions) Title V or XIX swing-bed NF inpatient routine | cs after Decem ne costs (line | mber 31 ot e 64 plus | f the c | ost reporting 5)(title XVII | period (See I only). For | | 64 65 |
| .00 | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine CAH (see instructions) Title V or XIX swing-bed NF inpatient routine (line 12 x line 19) | cs after Decem ne costs (line e costs throug | mber 31 of e 64 plus gh Decembe | f the colline 6 er 31 o | ost reporting 5)(title XVII f the cost re | period (See I only). For porting period | | 6: 6: |
| .00 | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine CAH (see instructions) Title V or XIX swing-bed NF inpatient routine (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine | cs after Decem ne costs (line e costs throug | mber 31 of e 64 plus gh Decembe | f the colline 6 er 31 o | ost reporting 5)(title XVII f the cost re | period (See I only). For porting period | | 64 65 67 |
| .00 | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine CAH (see instructions) Title V or XIX swing-bed NF inpatient routine (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine (line 13 x line 20) | cs after Decem ne costs (line e costs throug e costs after | nber 31 of e 64 plus gh Decembe December | f the c line 6 er 31 o | ost reporting 5)(title XVII f the cost re the cost repo | period (See I only). For porting period | | 6 6 6 |
| .00 .00 .00 | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine CAH (see instructions) Title V or XIX swing-bed NF inpatient routine (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine (line 13 x line 20) | es after Decem e costs (line e costs throug c costs after | mber 31 of e 64 plus gh December December | f the color fine 6 er 31 of the fine fine fine fine fine fine fine fin | ost reporting 5)(title XVII f the cost re the cost repo | period (See I only). For porting period | | 6: 6: 6: |
| .00 .00 .00 .00 | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine CAH (see instructions) Title V or XIX swing-bed NF inpatient routine (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine (line 13 x line 20) | e costs through costs after costs after costs after costs after costs after ty/ICE/MR rou | mber 31 of e 64 plus gh December December (line 67 Y, AND IC | f the color fine 6 er 31 of the color fine 6 er 31 of the color fine fine fine fine fine fine fine fine | ost reporting 5)(title XVII f the cost re the cost repo 68) | period (See I only). For porting period | 1 571 275 | 64 65 66 67 68 |
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| .00 .00 .00 .00 .00 | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine CAH (see instructions) Title V or XIX swing-bed NF inpatient routine (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Stilled nursing facility/other nursing facility (Skilled nursing facility) (adjusted general inpatient routine service cost (line 9 x line 7) | e costs through costs after coutine costs after coutine costs result ty/ICF/MR routs per diem (1) | mber 31 on e 64 plus gh December Oecember (line 67 Y, AND IC tine serv (line 70 ÷ | f the control of the | ost reporting 5)(title XVII f the cost re the cost repo 68) JLY st (line 37) | period (See I only). For porting period | 1,571,275 373.67 312,014 | 64 65 66 67 68 69 70 |
| .00 | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine CAH (see instructions) Title V or XIX swing-bed NF inpatient routine (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine litle V or XIX swing-bed NF inpatient routine skilled nursing facility/other nursing facility Adjusted general inpatient routine service corprogram routine service cost (line 9 x line 7 Medically necessary private room cost applications in the service of the service of the service of the service cost of the service of the service cost of the service of the service cost of the servi | e costs through costs after coutine costs after ty/ICF/MR roust per diem (1) | mber 31 on e 64 plus gh December December (line 67 Y, AND IC utine serv (line 70 ÷ | f the c line 6 er 31 o 31 of tline F/MR ON vice co line line | ost reporting 5)(title XVII f the cost re the cost repo 68) JLY st (line 37) | period (See I only). For porting period | 373.67 312,014 0 | 64 65 66 67 68 69 70 71 72 73 |
| .00 | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine CAH (see instructions) Title V or XIX swing-bed NF inpatient routine (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine stilled nursing facility/other nursing facility Adjusted general inpatient routine service cost (line 9 x line 7 Medically necessary private room cost application of the program general inpatient routine service cost (line 9 x line 7 Medically necessary private room cost application of the program general inpatient routine service copital-related cost allocated to inpatient routine the cost application of the program general inpatient routine service copital-related cost allocated to inpatient routine service copital-related cost allocated to inpatient routine service copital-related cost allocated to inpatient routine service copital-related cost allocated to inpatient routine service copital-related cost allocated to inpatient routine service copital-related cost allocated to inpatient routine service copital-related cost allocated to inpatient routine service copital-related cost allocated to inpatient routine service copital-related cost allocated to inpatient routine service copital-related cost allocated to inpatient routine service copital-related cost allocated to inpatient routine service copital-related cost allocated to inpatient routine service copital-related cost allocated to inpatient routine service copital-related cost allocated to inpatient routine service copital-related cost allocated to inpatient routine service copital-related cost allocated to inpatient routine service copital-related cost allocated to inpatient routine service copital-related cost allocated to inpatient routine service copital-related cost al | e costs (line costs through costs after coutine costs RSING FACILIT ty/ICF/MR rou st per diem (1) ble to Progra | mber 31 on e 64 plus gh December Cline 67 Y, AND IC utine serv Cline 70 = | f the c line 6 er 31 of + line F/MR ON vice cos - line (14 x line) | ost reporting 5)(title XVII f the cost re the cost repo 68) ILY st (line 37) 2) ne 35) | period (See I only). For porting period rting period | 373.67 312,014 0 312,014 | 64 65 66 67 68 69 70 71 72 73 74 |
| .00 .00 .00 .00 .00 .00 .00 .00 .00 | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine CAH (see instructions) Title V or XIX swing-bed NF inpatient routine (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine 13 x line 20) Total title V or XIX swing-bed NF inpatient routine Skilled nursing facility/other nursing facility Adjusted general inpatient routine service cost (line 9 x line 7 Medically necessary private room cost applicatotal program general inpatient routine servicapital-related cost allocated to inpatient routine 45) | e costs (line costs through costs after coutine costs RSING FACILIT ty/ICF/MR rou st per diem (1) able to Progra ce costs (line coutine service | mber 31 on e 64 plus gh December Cline 67 Y, AND IC utine serv Cline 70 = | f the c line 6 er 31 of + line F/MR ON vice cos - line (14 x line) | ost reporting 5)(title XVII f the cost re the cost repo 68) ILY st (line 37) 2) ne 35) | period (See I only). For porting period rting period | 373.67 312,014 0 | 64 65 66 67 68 69 70 71 72 73 74 |
| .00 .00 .00 .00 .00 .00 .00 .00 .00 | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine CAH (see instructions) Title V or XIX swing-bed NF inpatient routine (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine facility of the routine service cost (line 9 x line 7 Medically necessary private room cost application for the program general inpatient routine service cost (line 9 x line 7 Medically necessary private room cost application for the program general inpatient routine service (line 45) Per diem capital-related costs (line 75 ÷ line 75 for the program capital-related costs (line 75 ÷ line 75 for the program capital-related costs (line 75 ÷ line 75 ÷ line 75 ÷ line 75 ÷ line 75 + line | e costs through costs after costs after costs after costs after costs after costs after costs after costs after costs after costs after costs after costs after costs after costs after costs (line co | mber 31 on e 64 plus gh December Cline 67 Y, AND IC utine serv Cline 70 = | f the c line 6 er 31 of + line F/MR ON vice cos - line (14 x line) | ost reporting 5)(title XVII f the cost re the cost repo 68) ILY st (line 37) 2) ne 35) | period (See I only). For porting period rting period | 373.67 312,014 0 312,014 | 64 65 66 67 68 69 70 71 72 73 74 |
| .00 .00 .00 .00 .00 .00 .00 .00 .00 .00 | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine CAH (see instructions) Title V or XIX swing-bed NF inpatient routine (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine facility of the routine service cost (line 9 x line 7 Medically necessary private room cost applicational program general inpatient routine servicapital-related costs (line 75 ÷ line 7 for gram capital-related costs (line 9 x line 7 for gram capital-related costs (line 9 x line 7 for gram capital-related costs (line 9 x line 7 for gram capital-related costs (line 9 x line 7 for gram capital-related costs (line 9 x line 7 for gram capital-related costs (line 9 x line 7 for gram capital-related costs (line 9 x line 7 for gram capital-related costs (line 9 x line 7 for gram capital-related costs (line 9 x line 7 for gram capital-related costs (line 9 x line 7 for gram capital-related costs (line 7 for gram capital-related costs (line 9 x line 7 for gram capital-related costs (line 9 x line 7 for gram capital-related costs (line 9 x line 7 for gram capital-related costs (line 9 x line 7 for gram capital-related costs (line 7 for gram capital-related costs (line 9 x line 1 for gram capital-related costs (line 7 for gram capital-related costs (line 7 for gram capital-related costs (line 7 for gram capital-related costs (line 7 for gram capital-related costs (line 9 x line 1 for gram capital-related costs (line 9 x line 1 for gram capital-related costs (line 9 x line 1 for gram capital-related costs (line 9 x line 1 for gram capital-related costs (line 9 x line 1 for gram capital-related costs (line 9 x line 1 for gram capital-related costs (line 9 x line 1 for gram capital-related costs (line 9 x line 1 for gram capital-related costs (lin | e costs through costs after toutine costs resulting to the costs after ty/ICF/MR roust per diem (1) able to Prograce costs (line to prograce costs (li | mber 31 on e 64 plus gh December Cline 67 Y, AND IC utine serv Cline 70 = | f the c line 6 er 31 of + line F/MR ON vice cos - line (14 x line) | ost reporting 5)(title XVII f the cost re the cost repo 68) ILY st (line 37) 2) ne 35) | period (See I only). For porting period rting period | 373.67 312,014 0 312,014 0 0.00 | 64 65 66 67 68 69 70 71 72 73 74 75 |
| .00 .00 .00 .00 .00 .00 .00 .00 .00 .00 | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine CAH (see instructions) Title V or XIX swing-bed NF inpatient routine (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine stitle V or XIX swing-bed NF inpatient routine facility other nursing facility Adjusted general inpatient routine service cost (line 9 x line 7 Medically necessary private room cost application of the program general inpatient routine service cost (line 9 x line 7 Medically necessary private room cost application of the program general inpatient routine service (line 45) Per diem capital-related costs (line 75 ÷ line 1 program capital-related costs (line 7 × line 1 program capital-related costs (line 7 × line 1 program capital-related costs (line 7 × line 1 program capital-related costs (line 7 × line 1 program capital-related costs (line 7 × line 1 program capital-related costs (line 7 × line 1 program capital-related costs (line 7 × line 1 program capital-related costs (line 7 × line 2 program capital-related costs (line 9 x line 2 program capital-related costs (line 9 x line 2 program capital-related costs (line 9 x line 2 program capital-related costs (line 9 x line 2 program capital-related costs (line 9 x line 2 program capital-related costs (line 9 x line 2 program capital-related costs (line 9 x line 2 program capital-related costs (line 9 x line 2 program capital-related costs (line 9 x line 2 program capital-related costs (line 9 x line 2 program capital-related costs (line 9 x line 2 program capital-related costs (line 9 x line 2 program capital-related costs (line 9 x line 2 program capital-related costs (line 9 x line 2 program capital-related costs (line 9 x line 2 program capital-related costs (line 9 x line 2 progra | e costs through costs after ty/ICF/MR rousts per diem (1) ble to Prograce costs (1in outine service 2) 76) line 77) | mber 31 on e 64 plus gh December Cline 67 Y, AND IC utine serv Cline 70 ÷ am (line 1 ne 72 + li e costs (| f the c line 6 er 31 of 31 of tline F/MR ON vice cos line 73) (from wo | ost reporting 5)(title XVII f the cost re the cost repo 68) ILY st (line 37) 2) ne 35) orksheet B, Pa | period (See I only). For porting period rting period | 373.67 312,014 0 312,014 0 0.00 0 | 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 |
| .00 .00 .00 .00 .00 .00 .00 .00 .00 .00 | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine CAH (see instructions) Title V or XIX swing-bed NF inpatient routine (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine stitle V or XIX swing-bed NF inpatient routine facility/other nursing facility/other n | e costs (line costs through costs after toutine costs (start ty/ICF/MR roust per diem (start ty/ICF/MR roust per diem (start ty/ICF/MR roust per diem (start ty/ICF/MR roust per diem (start ty/ICF/MR roust per diem (start ty/ICF/MR roust per diem (start ty/ICF/MR roust per diem (start ty/ICF/MR roust per diem (start ty/ICF/MR roust per diem (start ty/ICF/MR roust) | mber 31 on e 64 plus gh December Cline 67 Y, AND IC utine serv Cline 70 ÷ am (line 1 ne 72 + li e costs (| f the c line 6 er 31 of 31 of tline F/MR ON vice cos line 73) (from wo | ost reporting 5)(title XVII f the cost re the cost repo 68) ILY st (line 37) 2) ne 35) orksheet B, Pa | period (See I only). For porting period rting period | 373.67 312,014 0 312,014 0 0.00 0 | 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 |
| .00 .00 .00 .00 .00 .00 .00 .00 .00 .00 | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine CAH (see instructions) Title V or XIX swing-bed NF inpatient routine (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine stitle v or XIX swing-bed NF inpatient routine facility/other nursing facility/other n | e costs (line costs through costs after ty/ICF/MR roust per diem (1) ble to Prograce costs (line costs (line costs (line costs (line costs (line costs (line costs (line costs (from costs | mber 31 on e 64 plus gh December Cline 67 Y, AND IC utine serv (line 70 = am (line 1 e 72 + li e costs (| f the c line 6 er 31 of 31 of tline F/MR ON vice cos line 73) (from wo | ost reporting 5)(title XVII f the cost re the cost repo 68) ILY st (line 37) 2) ne 35) orksheet B, Pa | period (See I only). For porting period rting period | 373.67 312,014 0 312,014 0 0.00 0 0 | 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 |
| .00 .00 .00 .00 .00 .00 .00 .00 .00 .00 | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine CAH (see instructions) Title V or XIX swing-bed SNF inpatient routine (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine service cost (line 9 x line 7 Adjusted general inpatient routine service cost (line 9 x line 7 Medically necessary private room cost applicatotal Program general inpatient routine service (Apital-related cost allocated to inpatient routine 10, line 45) Per diem capital-related costs (line 75 ÷ line 11) Program capital-related costs (line 74 minus Aggregate charges to beneficiaries for excess Total Program routine service cost for compa Inpatient routine service cost per diem limit Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li | cs after December costs (line excess through costs after coutine costs (line excess) (line excess (line exces | mber 31 on e 64 plus gh December Cline 67 Y, AND IC utine serv (line 70 ÷ am (line 1 ne 72 + line ce costs (| f the c line 6 er 31 of 31 of tline F/MR ON vice cos line 73) (from wo | ost reporting 5)(title XVII f the cost re the cost repo 68) ILY st (line 37) 2) ne 35) orksheet B, Pa | period (See I only). For porting period rting period | 373.67 312,014 0 312,014 0 0.00 0 0 | 6.6 6.6 6.6 6.6 6.7 7.7 7.7 7.7 7.7 7.8 7.9 8.0 8.1 |
| .00 .00 .00 .00 .00 .00 .00 .00 .00 .00 | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine (ANF (see instructions)) Title V or XIX swing-bed SNF inpatient routine (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Skilled nursing facility/other nursing facility (adjusted general inpatient routine service cost (line 9 x line 7) Medically necessary private room cost applicated application of the program general inpatient routine servicated (application) Total Program general inpatient routine servicated (application) Total Program general inpatient routine servicated (application) Total Program general inpatient routine servicated (application) Total Program general inpatient routine servication (application) Total Program capital-related costs (line 75 ÷ line 7) Program capital-related costs (line 74 minus Aggregate charges to beneficiaries for excess Total Program routine service cost (line 74 minus Aggregate charges to beneficiaries for compatine program routine service cost for compatine program routine service cost limitation (line 1) Reasonable inpatient routine service cost limitation (line 1) | cs after December costs (line costs through costs after coutine costs resulting to the cost of the cost of the cost of the cost of the cost of the cost of the costs (line costs (line costs (line costs (from cos | mber 31 on e 64 plus gh December Cline 67 Y, AND IC utine serv (line 70 ÷ am (line 1 ne 72 + line ce costs (| f the c line 6 er 31 of 31 of tline F/MR ON vice cos line 73) (from wo | ost reporting 5)(title XVII f the cost re the cost repo 68) ILY st (line 37) 2) ne 35) orksheet B, Pa | period (See I only). For porting period rting period | 373.67 312,014 0 312,014 0 0.00 0 0 0 0 0.00 0 0 312,014 | 64 65 66 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 |
| .00 .00 .00 .00 .00 .00 .00 .00 .00 .00 | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine CAH (see instructions) Title V or XIX swing-bed NF inpatient routine (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine facility of the routine service cost (line 9 x line 7 Adjusted general inpatient routine service cost (line 9 x line 7 Medically necessary private room cost applicated routine service cost (line 9 x line 7 Amount of 1 Adjusted general inpatient routine service cost (line 7 Sine 4 Sine 7 Amount of 1 Amount of | cs after December costs (line e costs through costs after coutine costs (RSING FACILIT ty/ICF/MR roust per diem (1) (l) (l) (l) (l) (l) (l) (l) (l) (l) (l | mber 31 on e 64 plus gh December (line 67 Y, AND IC utine serv (line 70 ÷ am (line 1 ne 72 + li ne costs (provider cost limi sil) ons) | f the c line 6 er 31 of + line F/MR ON vice con line 73) (from Wo | ost reporting 5)(title XVII f the cost re the cost repo 68) ILY st (line 37) 2) ne 35) orksheet B, Pa | period (See I only). For porting period rting period | 373.67 312,014 0 312,014 0 0.00 0 0 0 0 0.00 0 0 312,014 176,323 | 64 65 68 68 69 70 72 73 74 75 76 77 78 80 81 82 83 84 |
| .000 .000 .000 .000 .000 .000 .000 .00 | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine CAH (see instructions) Title V or XIX swing-bed NF inpatient routine (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine stitle v or XIX swing-bed NF inpatient routine facility/other nursing/other nursing/other nursin | e costs (line costs through costs after coutine costs RSING FACILIT ty/ICF/MR rou st per diem (1) ble to Progra ce costs (line outine service e 2) 76) line 77) costs (from rison to the ation ne 9 x line 8 ee instructio tructions) see instructio | mber 31 on e 64 plus gh December Cline 67 Y, AND IC with a service from (line 1) e 72 + line 72 + line 72 + line 72 + line 72 + line 73 | f the c line 6 er 31 of + line F/MR ON vice con line 73) (from Wo | ost reporting 5)(title XVII f the cost re the cost repo 68) ILY st (line 37) 2) ne 35) orksheet B, Pa | period (See I only). For porting period rting period | 373.67 312,014 0 312,014 0 0.00 0 0 0 0.00 0 312,014 176,323 | 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 80 81 82 83 84 85 |
| .00 .00 .00 .00 .00 .00 .00 .00 .00 .00 | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine CAH (see instructions) Title V or XIX swing-bed NF inpatient routine (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine stitle V or XIX swing-bed NF inpatient routine service cost (line 9 x line 7 AMI) Skilled nursing facility/other nursing facility (skilled nursing facility) Medically necessary private room cost applicated program general inpatient routine service cost (line 9 x line 7 AMI) Total Program general inpatient routine service, line 45) Per diem capital-related costs (line 75 ÷ line 1 Program capital-related costs (line 7 4 minus Aggregate charges to beneficiaries for excess Total Program routine service cost (line 7 4 minus Aggregate charges to beneficiaries for excess Total Program routine service cost per diem limit Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li Reasonable inpatient routine service cost limitation (li Reasonable inpatient routine service (see ins Utilization review - physician compensation (Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS | e costs (line costs through costs after coutine costs RSING FACILIT ty/ICF/MR rou st per diem (1) ble to Progra ce costs (line outine service e 2) 76) line 77) costs (from rison to the ation ne 9 x line 8 ee instructio tructions) see instructio | mber 31 on e 64 plus gh December Cline 67 Y, AND IC with a service from (line 1) e 72 + line 72 + line 72 + line 72 + line 72 + line 73 | f the c line 6 er 31 of + line F/MR ON vice con line 73) (from Wo | ost reporting 5)(title XVII f the cost re the cost repo 68) ILY st (line 37) 2) ne 35) orksheet B, Pa | period (See I only). For porting period rting period | 373.67 312,014 0 312,014 0 0.00 0 0 0 0 0.00 0 0 312,014 176,323 | 72 73 74 75 76 77 78 79 80 |
| .00 .00 .00 .00 .00 .00 .00 .00 .00 .00 | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine CAH (see instructions) Title V or XIX swing-bed NF inpatient routine (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine stitle v or XIX swing-bed NF inpatient routine facility/other nursing/other nursing/other nursin | cs after December costs (line costs through costs after coutine costs (line costs resulting for the costs of the costs (line costs (line costs (line costs (line costs (line costs (from costs)))))))). | mber 31 on e 64 plus gh December Cline 67 Y, AND IC utine serv (line 70 = am (line 1 ne 72 + li ne costs (provider cost limi sins) ons) hrough 85 | f the c line 6 er 31 of + line F/MR ON vice co: - line 73) (from We records tation | ost reporting 5)(title XVII f the cost re the cost repo 68) ILY st (line 37) 2) ne 35) orksheet B, Pa | period (See I only). For porting period rting period | 373.67 312,014 0 312,014 0 0.00 0 0 0 0.00 0 312,014 176,323 | 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 80 81 82 83 84 85 |

| Health Financial Systems | WABASH COUN | TY HOSPITAL | | In Lie | eu of Form CMS- | 2552-10 |
|---|-------------|-------------|--|----------------------------|--------------------------------|----------------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provid | er CCN: 151310 | Period: From 01/01/2012 | Worksheet D-1 | |
| | | Compor | ent CCN: 15536 | то 12/31/2012 | Date/Time Pre 5/29/2013 8:0 | pared: 8 am |
| | | Т | itle XVIII | Skilled Nursing | PPS | |
| | | | - Constitution of the contract | Facility | | |
| Cost Center Description | Cost | Routine Co | st column 1 | ÷ Total | Observation | |
| | | (from line | 27) column 2 | Observation | Bed Pass | |
| | | 1 | 1 | Bed Cost (from | | l |
| | | | | line 89) | (col. 3 x col. | |
| | | | | 11110 057 | 4) (see | |
| | | | | 1 | instructions) | |
| | 1.00 | 2,00 | 3.00 | 4.00 | 5.00 | |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | | | | 1.00 | 3.00 | |
| 90.00 Capital-related cost | C031 | N | 0 000 | 000 | T | |
| • | ' | J | 0.000 | 1 | 1 0 | 90.00 |
| 91.00 Nursing School cost | (| 0 | 0.000 | 000 0 | 0 | 91.00 |
| 92.00 Allied health cost | | 0 | 0.000 | 000 | 0 | 92.00 |
| 93.00 All other Medical Education | (| 0 | 0.000 | 000 | 0 | 93.00 |

| COMPUTATION | OF INPATIENT OPERATING COST WABASH COUNTY | Provider CCN: 151310 | Period: | u of Form CMS- Worksheet D-1 | | |
|------------------------------|---|--|----------------------------------|-----------------------------------|--------------|--|
| | | | From 01/01/2012 To 12/31/2012 | Date/Time Pre 5/29/2013 8:0 | | |
| | Cost Center Description | Title XIX | Hospital | PPS | 70 am | |
| DADT | I - ALL PROVIDER COMPONENTS | | | 1.00 | | |
| INPAT | TENT DAYS | | | | - | |
| 1.00 Inpat 2.00 Inpat | tient days (including private room days and swing-bed da | ys, excluding newborn) | | 2,802 | | |
| do no | tient days (including private room days, excluding swing ate room days (excluding swing-bed and observation bed d ot complete this line. | ays). If you have only pr | ivate room days, | 2,557 0 | | |
| 5.00 Total | private room days (excluding swing-bed and observation swing-bed SNF type inpatient days (including private reting period | bed days) oom days) through Decembe | r 31 of the cost | 2,265 178 | | |
| 6.00 Total repor | Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cos reporting period (if calendar year, enter 0 on this line) | | | | | |
| 7.00 Total repor | swing-bed NF type inpatient days (including private ro ting period | | | 67 | 7. | |
| repor | swing-bed NF type inpatient days (including private ro ting period (if calendar year, enter 0 on this line) | | I | 0 | 8. | |
| 3.00 Total newbo | inpatient days including private room days applicable orn days) | | | 64 | 9. | |
| LITTOU | n-bed SNF type inpatient days applicable to title XVIII or igh December 31 of the cost reporting period (see instruc | ctions) | | 0 | 10. | |
| Decem | l-bed SNF type inpatient days applicable to title XVIII of the cost reporting period (if calendar year, of the cost reporting period (if calendar year, of the cost reporting period (if calendar year, of the cost reporting period (if calendar year, of the cost reporting period (if calendar year, of the cost reporting period (if calendar year)). | enter () on this line) | | 0 | 11. | |
| Enrou | p-bed NF type inpatient days applicable to titles V or XI Input NE type inpatient days applicable to titles V or XI Input NE type inpatient days applicable to title V | | | | 12. 13. | |
| aitei | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days) | | | | | |
| 5.00 Total | nursery days (title V or XIX only) | ram (excluding swing-bed | lays) | 0 | | |
| .6.00 Nurse SWING | Nursery days (title v or XIX only) SWING BED ADJUSTMENT | | | | | |
| repor | are rate for swing-bed SNF services applicable to service ting period | | | | 17. | |
| i repor | are rate for swing-bed SNF services applicable to service ting period | | | | 18. | |
| leboi | aid rate for swing-bed NF services applicable to service ting period aid rate for swing-bed NF services applicable to service | | 1 | 132.00 | 19 | |
| (Epoi | ting period general inpatient routine service cost (see instruction | | ie cost | 132.00 | | |
| 2.00 Swing 5 x 1 | -bed cost applicable to SNF type services through Decemb ine 17) | per 31 of the cost report | | 3,339,461 0 | | |
| 1/2 1110 | | | | 0 | 23. | |
| , , , , | -bed cost applicable to NF type services through December ine 19) | | | 8,844 | 24. | |
| | -bed cost applicable to NF type services after December e 20) swing-bed cost (see instructions) | 31 of the cost reporting | period (line 8 | 0 | 25. | |
| 7.00 Genera | al inpatient routine service cost net of swing-bed cost E ROOM DIFFERENTIAL ADJUSTMENT | (line 21 minus line 26) | | 225,609 3,113,852 | | |
| 8.00 Genera | al inpatient routine service charges (excluding swing-be | ed charges) | | 4 000 045 | 3.0 | |
| 7.00 [Privat | te room charges (excluding swing-bed charges) | geo/ | | 4,988,845 0 | 28. 29. | |
| 0.00 Semi-p 00 Genera | private room charges (excluding swing-bed charges) | | | | | |
| .00 Genera | al inpatient routine service cost/charge ratio (line 27 | ÷ line 28) | | 0.624163 | | |
| .00 Averag | ge private room per diem charge (line 29 ÷ line 3) | | | 0.00 | | |
| .00 Averag | ge semi-private room per diem charge (line 30 ÷ line 4) | | | 2,202.58 | | |
| .00 Averag | ge per diem private room charge differential (line 32 mi | nus line 33)(see instruct | ions) | 0.00 | | |
| .oo Averag | ge per urem private room cost differential (line 34 v li | ne 31) | | 0.00 | | |
| .uu Genera | te room cost differential adjustment (line 3 x line 35) al inpatient routine service cost net of swing-bed cost | and private room cost dif | forontial (line | 0 | 36. | |
| PART I | I - HOSPITAL AND SUBPROVIDERS ONLY | | referrial (TIME | 3,113,852 | 3/. | |
| PROGRA | M INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADDI | JSTMENTS | | | | |
| o.vo Aujust | ed general inpatient routine service cost par diam (see | inctnuchiene | | 1 217 70 | 20 | |
| 7.00 Priogra | um general impatient routine service cost (line 9 v line | 387 | | 1,217.78 | | |
| Medica | llly necessary private room cost applicable to the progr | am (lina 14 v lin- ar) | | 77,938 | | |
| | Program general inpatient routine service cost (line 39 | 7' 40' | | U | 40.0 41.0 | |

| .OMPU | TATION OF INPATIENT OPERATING COST | | | Provider | CCN: 151310 | Period: | worksheet D-1 | |
|-----------------------------|--|-----------------|--------------|------------|--|----------------------------------|--|--------------|
| | | | | | | From 01/01/2012 To 12/31/2012 | | |
| | | | | | | то 12/31/2012 | Date/Time Pre 5/29/2013 8:0 | pare 8 am |
| - | Cost Costs Decided | | · | | le XIX | Hospital | PPS | |
| | Cost Center Description | Total | | Total | Average Per | Program Days | Program Cost | |
| | | Inpatient Cost | Tubai | rent bays | col. 2) | + | (col. 3 x col. | |
| otenen and an experience of | A | 1.00 | | 2.00 | 3.00 | 4.00 | 4) 5.00 | ļ |
| 2.00 | NURSERY (title V & XIX only) | Ō | İ | 0 | administration factors with a see a springer constraint, e.g. 1 of | | | 42. |
| 2 00 | Intensive Care Type Inpatient Hospital Units | | - | | | | | 1 |
| | INTENSIVE CARE UNIT | | | | | | P-70001.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1. | 43. |
| 4.00 5.00 | | | | | | | | 44. |
| | SURGICAL INTENSIVE CARE UNIT | | İ | | | | , | 45. |
| | OTHER SPECIAL CARE (SPECIFY) | | | | | | | 46. |
| | Cost Center Description | | A 1700000000 | | | | | 47. |
| | | | | | | | 1.00 | |
| 8.00 | Program inpatient ancillary service cost (Wks | st. D-3, col. : | 3, li | ne 200) | | | 143,345 | |
| 9.00 | Total Program inpatient costs (sum of lines | 41 through 48) | (see | instructio | ns) | | 221,283 | 49. |
| 0.00 | PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa | | | | | | | |
| 0.00 | III) | atient routine | serv | ices (from | i Wkst. D, su | m of Parts I and | 2,427 | 50. |
| 1.00 | Pass through costs applicable to Program inpa | atient ancilla | ry se | rvices (fr | om Wkst. D | SUM of Parts TT | 3,871 | 51 |
| | and IV) | | , | (// | | | 3,071 | ٦١. |
| 2.00 | | 50 and 51) | _ | | | | 6,298 | 52. |
| 3.00 | Total Program inpatient operating cost excluded medical education costs (line 49 minus line 5 | ding capital re | elate | d, non-phy | sician anest | hetist, and | 214,985 | 53. |
| | TARGET AMOUNT AND LIMIT COMPUTATION | | - | | | | | |
| | Program discharges | | | | | | 0 | 54. |
| .00 | Target amount per discharge | | | | | | 0.00 | |
| 5.00 | Target amount (line 54 x line 55) | | | | | | 0.00 | |
| .00 | Difference between adjusted inpatient operati | ing cost and ta | arget | amount (1 | ine 56 minus | line 53) | 0 | 57. |
| 3.00 | | | | | | | 0 | 58. |
| | Lesser of lines 53/54 or 55 from the cost repmarket basket | porting period | endi | ng 1996, u | pdated and c | ompounded by the | 0.00 | 59. |
| .00 | | ost report ur | nda+no | l by the m | ankot backot | | 0.00 | |
| .00 | IT line 53/54 is less than the lower of lines | : 55. 59 or 60 | enter | the lace | ar of 50% of | the amount by | 0.00 | 60. |
| | which operating costs (line 53) are less than | i expected cost | s (1i | nes 54 x | 60), or 1% o | f the target | U | 61. |
| | dmount (line 56), Otherwise enter zero (see i | nstructions) | • | | ,, | . Line carge | | |
| 2.00 | | | | | | | 0 | 62. |
| | Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST | ent (see instru | ictior | <u> </u> | · | | 0 | 63. |
| .00 | Medicare swing-bed SNF inpatient routine cost | s through Dece | mber | 31 of the | COST report | ing pariod (See | 0 | 61 |
| | INSCRUCTIONS)(TITLE XVIII ONLY) | | | | | | U | 64. |
| 5.00 | Medicare swing-bed SNF inpatient routine cost | s after Decemb | er 31 | . of the c | ost reporting | period (See | 0 | 65. |
| 5.00 | instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin | | | 7. 6 | -> < | | | |
| | CAH (see instructions) | ie costs (Tine | 64 рі | us inne 6 | 5)(title XVI | [I only). For | 0 | 66. |
| 7.00 | Title V or XIX swing-bed NF inpatient routine | costs through | Dece | mber 31 o | f the cost re | norting period | 8,844 | 67 |
| | (Time 12 x Time 19) | | | | | | 0,044 | 67. |
| 3.00 | Title V or XIX swing-bed NF inpatient routine | costs after D | ecemb | er 31 of | the cost repo | orting period | o | 68. |
| 00.0 | (line 13 x line 20) Total title V or XIX swing-bed NF inpatient r | | | | | | | |
| | PART III - SKILLED NURSING FACILITY, OTHER NU | DULINE COSTS (| TINE | b/ + line | 68) | | 8,844 | 69. |
| | >Kliled nursing facility/other nursing facili | tv/TCF/MR rout | ina c | arvica co | c+ (line 27) | | | 70 |
| | Adjusted general inpatient routine service co | st ner diem (1 | ine 7 | 0 ÷ line | 2) | | | 70. 71. |
| | Program routine service cost (line 9 x line 7 | 1) | | | | | | 72. |
| .00 | Medically necessary private room cost applica | ble to Program | (lin | e 14 x li | ne 35) | | | 73. |
| .00 | Total Program general inpatient routine servi | ce costs (line | 72 + | line 73) | | | | 74. |
| | Capital-related cost allocated to inpatient r 26, line 45) | outine service | cost | s (trom W | orksheet B, F | art II, column | | 75. |
| .00 | Per diem capital-related costs (line 75 ÷ lin | e 2) | | | | | | |
| .00 | Program capital-related costs (line 9 x line | 76) | | | | | | 76. |
| .00 | Inpatient routine service cost (line 74 minus | line 77) | | | | | | 77. 78. |
| .00 | Aggregate charges to beneficiaries for excess | costs (from n | rovid | er record | s) | 1 | | 79. |
| .00 | Total Program routine service costs for compa | rison to the c | ost 1 | imitation | (line 78 min | us line 79) | | 80. |
| .00 | Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li | ation | | | | | | 81. |
| .00 | Reasonable inpatient routine service costs (se | ne y x line 81 |) | | | | 1 | 82. |
| .00 | Program inpatient ancillary services (see ins | tructions) | | | | | | 83. |
| .00 | Utilization review - physician compensation (| see instruction | ns) | | | | | 84. |
| .սս լ | lotal Program inpatient operating costs (sum o | of lines 83 th | rouah | 85) | | | | 85. |
| | PAK! IV - COMPUTATION OF OBSERVATION RED PASS | THROUGH COST | | | | | | 86. |
| .00 | Total observation bed days (see instructions) | | | | | | 292 | 87.0 |
| | Adjusted general inpatient routine cost per d | iem (line 27 ÷ | line | 2) | | | 1,217.78 | |
| .00 | Observation bed cost (line 87 x line 88) (see | inctmat | | | | i i | 355,592 | |

| | Financial Systems | WABASH COUNT | Y HOSPITAL | | In Lie | u of Form CMS- | 2552-10 |
|--------|---|--------------|----------------|------------|----------------------------|--------------------------------|---------|
| COMPUT | ATION OF INPATIENT OPERATING COST | | Provider | | Period: From 01/01/2012 | | |
| | | | | | то 12/31/2012 | Date/Time Pre 5/29/2013 8:0 | |
| | | | Tit | le XIX | Hospital | PPS | |
| | Cost Center Description | Cost | Routine Cost | column 1 ÷ | Total | Observation | |
| | | | (from line 27) | column 2 | Observation | Bed Pass | |
| | | | | | Bed Cost (from | Through Cost | |
| | | | | | line 89) | (col. 3 x col. | |
| | | | | | | 4) (see | |
| | | | | | | instructions) | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | COMPUTATION OF OBSERVATION BED PASS THROUGH | COST | | | | | |
| | Capital-related cost | 103,983 | 3,113,852 | 0.033394 | 355,592 | 11,875 | 90.00 |
| | Nursing School cost | 0 | 3,113,852 | 0.00000 | 355,592 | , | 91.00 |
| | Allied health cost | 0 | 3,113,852 | 0.000000 | 355,592 | 0 | 92.00 |
| 93.00 | All other Medical Education | 0 | 3,113,852 | 0.00000 | | _ | 1 |

| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider | CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | | pared |
|---|---------------------------|----------------------------|---|---|----------|
| | Titl | e XVIII | Hospital | Cost | 0 0,111 |
| Cost Center Description | n ne-mahalan na mahanan - | Ratio of Cos To Charges | t Inpatient Program Charges | Inpatient Program Costs (col. 1 x col. 2) | |
| INPATIENT ROUTINE SERVICE COST CENTERS | - | 1.00 | 2.00 | 3.00 | ↓ |
| 30.00 03000 ADULTS & PEDIATRICS | | T | 3 371 770 | | |
| 43.00 04300 NURSERY | | | 2,371,779 | | 30.0 |
| ANCILLARY SERVICE COST CENTERS | | | | | 43.0 |
| 50.00 O5000 OPERATING ROOM | | 0.54934 | 170,885 | 93,876 | 50.0 |
| 51.00 05100 RECOVERY ROOM | | 0.39370 | | | |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | | 0.00000 | , | 9,967 | 1 |
| 53.00 05300 ANESTHESIOLOGY | | 0.12705 | _ | _ | |
| 54.00 05400 RADIOLOGY-DIAGNOSTIC | | 0.22656 | , | | |
| 56.00 O5600 RADIOISOTOPE | | 0.26875 | , | | |
| 50.00 06000 LABORATORY | | 0.23474 | , | -, | |
| 53.00 06300 BLOOD STORING, PROCESSING & TRANS. | | 0.58432 | , | , | |
| 66.00 06600 PHYSICAL THERAPY | | 0.64787 | , | , | |
| 59.00 06900 ELECTROCARDIOLOGY | | 0.45104 | | | 1 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | 0.48655 | | , | |
| 2.00 07200 IMPL. DEV. CHARGED TO PATIENT | | 0.20872 | | 23,253 | |
| 73.00 DRUGS CHARGED TO PATIENTS | | 0.20246 | 2,153,570 | 436,027 | |
| OUTPATIENT SERVICE COST CENTERS | | | | | 1 |
| 0.00 09000 CLINIC | | 0.34130 | 0 8 | 0 | 90.0 |
| 00.01 09001 SENIOR CARE | | 0.83668 | 0 | 0 | |
| 01.00 09100 EMERGENCY | | 0.44990 | 2,535 | 1,141 | |
| 12.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | 0.38844 | 4 0 | | 92.0 |
| 00.00 Total (sum of lines 50-94 and 96-98) | | | 4,877,691 | 1,449,870 | |
| Less PBP Clinic Laboratory Services-Program only charges (1 | ine 61) | | 0 | • | 201.0 |
| 02.00 Net Charges (line 200 minus line 201) | | | 4,877,691 | | 202.0 |

| Health Financial Systems WABASH COUN INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | | CCN: 151310 | Period: | u of Form CMS- Worksheet D-3 | |
|--|---------------|---------------|------------------|---------------------------------|--------|
| ZIN / TOTAL COST AT ON ZONALN | Frovider | CCN. 131310 | From 01/01/2012 | WOLKSHEEL D-3 | |
| | Componen | t CCN: 15Z310 | To 12/31/2012 | | pared: |
| | | | | 5/29/2013 8:0 | 8 am |
| Cost Center Description | Tit! | | Swing Beds - SNF | | |
| Cost Center Description | | Ratio of Cos | | Inpatient | |
| | | To Charges | Program | Program Costs | |
| | | | Charges | (col. 1 x col. | |
| | | 1.00 | 2.00 | 2) 3.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | 1.00 | 2.00 | 3.00 | |
| 30.00 03000 ADULTS & PEDIATRICS | | | 0 | | 30.00 |
| 43.00 04300 NURSERY | | | U | | 43.00 |
| ANCILLARY SERVICE COST CENTERS | | | | | 73.00 |
| 50.00 05000 OPERATING ROOM | | 0.54934 | 19 0 | 0 | 50.0 |
| 51.00 05100 RECOVERY ROOM | | 0.39370 | | 0 | |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | | 0.00000 | _ | 0 | |
| 53.00 05300 ANESTHESIOLOGY | | 0.1270 | _ | 0 | 53.0 |
| 54.00 05400 RADIOLOGY-DIAGNOSTIC | | 0.22656 | | 1,759 | |
| 56.00 05600 RADIOISOTOPE | | 0.2687 | | 0 | 1 |
| 60.00 06000 LABORATORY | | 0.23474 | 19 37,880 | 8,892 | |
| 63.00 06300 BLOOD STORING, PROCESSING & TRANS. | | 0.58432 | 4,860 | 2,840 | |
| 66.00 06600 PHYSICAL THERAPY | | 0.64787 | 72 29,893 | 19,367 | 66.0 |
| 69.00 06900 ELECTROCARDIOLOGY | | 0.45104 | 12 22,796 | 10,282 | 69.0 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | 0.48655 | 3,547 | 1,726 | 71.0 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | | 0.20872 | 25 0 | 0 | 72.0 |
| 73.00 O7300 DRUGS CHARGED TO PATIENTS | | 0.20246 | 218,730 | 44,286 | 73.0 |
| OUTPATIENT SERVICE COST CENTERS | | | | | j |
| 90.00 09000 CLINIC | | 0.34130 | | 0 | 90.00 |
| 90.01 09001 SENIOR CARE | | 0.83668 | | 0 | 90.0 |
| 91.00 09100 EMERGENCY | | 0.44990 | - | 0 | 91.0 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | 0.38844 | | 0 | 92.00 |
| 200.00 Total (sum of lines 50-94 and 96-98) 201.00 Less PBP Clinic Laboratory Services-Program only char | | | 325,468 | 89,152 | |
| | ges (line 61) | | 0 | | 201.0 |
| 202.00 Net Charges (line 200 minus line 201) | | 1 | 325,468 | | 202.00 |

| INPAT] | ENT ANCILLARY SERVICE COST APPORTIONMENT | rovider | CCN: 151310 | Period: | Worksheet D- | 3 |
|--------|--|--------------------------|----------------------------|----------------------------------|---|------------------|
| | c | Component CCN: 155365 To | | From 01/01/2012 To 12/31/2012 | | epared: 08 am |
| | | Titl | e XVIII | Skilled Nursing Facility | PPS | |
| | Cost Center Description | | Ratio of Cos To Charges | | Inpatient Program Costs (col. 1 x col. 2) | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | 1.00 | 2.00 | 3.00 | |
| 30.00 | 03000 ADULTS & PEDIATRICS | | T | | | |
| 43.00 | 04300 NURSERY | | | 0 | | 30.00 |
| | ANCILLARY SERVICE COST CENTERS | | L | | <u> </u> | 43.00 |
| 50.00 | 05000 OPERATING ROOM | | 0.5493 | 49 0 | 0 | 50.00 |
| 51.00 | 05100 RECOVERY ROOM | | 0.3937 | . (| | |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | | 0.0000 | | ď | 1 |
| 53.00 | 05300 ANESTHESIOLOGY | | 0.1270 | | Ö | 1 |
| | 05400 RADIOLOGY-DIAGNOSTIC | | 0.2265 | | | |
| | 05600 RADIOISOTOPE | | 0.2687 | | | |
| | 06000 LABORATORY | | 0.2347 | 49 33,306 | | |
| 63.00 | 06300 BLOOD STORING, PROCESSING & TRANS. | | 0.5843 | | | |
| | 06600 PHYSICAL THERAPY | | 0.6478 | 72 164,808 | 106,774 | 66.00 |
| | 06900 ELECTROCARDIOLOGY | | 0.4510 | 41,946 | 18,919 | 69.00 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | 0.4865 | 59 1,684 | 819 | 71.00 |
| | 07200 IMPL. DEV. CHARGED TO PATIENT | | 0.2087 | 25 0 | o | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | | 0.2024 | 57 <u>190,596</u> | 38,589 | 73.00 |
| 00 00 | OUTPATIENT SERVICE COST CENTERS 09000 CLINIC | | | | | |
| | 09001 SENIOR CARE | | 0.3413 | | 0 | 00.00 |
| | 09100 EMERGENCY | | 0.8366 | | 0 | 1 20.01 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | 0.44990 | | 0 | |
| 200.00 | Total (sum of lines 50-94 and 96-98) | | 0.3884 | _ | 0 | 32.00 |
| 201.00 | | 61) | | 446,710 | 176,323 | 1 |
| 202.00 | | ne 61) | | 0 | | 201.00 |
| 202.00 | ince charges (time 200 minus line 201) | | | 446,710 | 1 | 202.00 |

| Health Financial Systems | WABASH COUNTY HOSPITAL | | | u of Form CMS- | |
|---|---------------------------------------|-------------|----------------------------|----------------------|----------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CC | | Period: From 01/01/2012 | Worksheet D-3 | 3 |
| | | | To 12/31/2012 | Date/Time Pre | nared: |
| | | | ,, | 5/29/2013 8:0 | |
| | Title | XIX | Hospital | PPS | |
| Cost Center Description | Ra | itio of Cos | t Inpatient | Inpatient | |
| | 1 | To Charges | | Program Costs | |
| | | | Charges | (col. 1 x col. | |
| | pound and tree | | | 2) | |
| TARA TERMINA | | 1.00 | 2.00 | 3.00 | <u> </u> |
| 30.00 O3000 ADULTS & PEDIATRICS | | | 1 | | |
| 43.00 04300 NURSERY | | | 141,852 | | 30.00 |
| | | | 0 | | 43.00 |
| ANCILLARY SERVICE COST CENTERS 50.00 OFFRATING ROOM | | 0 54024 | 24 602 | | |
| 51.00 05100 RECOVERY ROOM | | 0.54934 | , | 13,565 | |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | | 0.39370 | , | 1,533 | |
| 53.00 05300 ANESTHESIOLOGY | | 0.00000 | -1 | 0 | |
| 54.00 05400 RADIOLOGY-DIAGNOSTIC | | 0.12703 | ,1 | 616 | |
| 56.00 05600 RADIOISOTOPE | | 0.22636 | . , | 7,732 | 1 |
| 60.00 06000 LABORATORY | | 0.28673 | -1 | 11 700 | 30.00 |
| 63.00 06300 BLOOD STORING, PROCESSING & TRANS. | | 0.23474 | | 11,709 | |
| 66.00 06600 PHYSICAL THERAPY | | 0.564787 | | 72 | |
| 69.00 06900 ELECTROCARDIOLOGY | | 0.45104 | -, | 4,343 | 1 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | 0.48655 | -1, | 13,791 58,669 | |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | | 0.20872 | , | 30,009 0 | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | | 0.20246 | -1 | 23,879 | 1 |
| OUTPATIENT SERVICE COST CENTERS | | 0.20240 | /]11/, 541 | 23,679 | 73.00 |
| 90.00 09000 CLINIC | · · · · · · · · · · · · · · · · · · · | 0.34130 | 8 0 | | 90.00 |
| 90.01 09001 SENIOR CARE | | 0.83668 | | 0 | |
| 91.00 09100 EMERGENCY | | 0.44990 | | 7.436 | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | 0.38844 | | 7,430 | 1 - |
| 200.00 Total (sum of lines 50-94 and 96-98) | | 3.50044 | 409,888 | 143,345 | |
| 201.00 Less PBP Clinic Laboratory Services-F | rogram only charges (line 61) | | .05,000 | ±73,343 | 201.00 |
| Net Charges (line 200 minus line 201) | 3 | | 409,888 | | 202.00 |

| CULATION OF REIMBURSE | MENT SETTLEMENT | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | | |
|---|--|------------------------------|---|------------------------|------------|
| | | Title XVIII | | 5/29/2013 8:0 | |
| | A - We show the second of the | TICLE XVIII | Hospital | Cost | Τ |
| PART B - MEDICAL | AND OTHER HEALTH SERVICES | | | 1.00 | |
| 0 Medical and other | services (see instructions) | | | 5,612,332 | 1. |
| 0 Medical and other | services reimbursed under OPPS (see ins | tructions) | | 0 | 1 |
| <pre>0 PPS payments 0 Outlier payment (</pre> | son instructions) | | | 0 | 1 - |
| O Enter the hospita | l specific payment to cost ratio (see in: | structions) | | 0 000 | 1 ' |
| 0 Line 2 times line | 5 | structions) | | 0.000 | |
| O Sum of line 3 plu | s line 4 divided by line 6 | | | 0.00 | ł |
| O Transitional corr | idor payment (see instructions) | | | 0 | 1 |
| O Ancillary service OO Organ acquisition | other pass through costs from Worksheet | D, Part IV, column 13, line | 200 | 0 | - |
| | f lines 1 and 10) (see instructions) | | | 5 612 222 | 1 -0 |
| COMPUTATION OF LES | SER OF COST OR CHARGES | | | 5,612,332 | ļ ++ |
| Reasonable charges | And the state of t | 7.3 | | | 1 |
| OO Ancillary service | charges | | | 0 | 12 |
| Organ acquisition | charges (from Worksheet D-4, Part III, in the charges (sum of lines 12 and 13) | line 69, col. 4) | | 0 | |
| Customary charges | marges (sum of Times 12 and 13) | | | 0 | 14 |
| O Aggregate amount | actually collected from patients liable t | for payment for services on | a charge hasis | <u> </u> | 15 |
| JU Amounts that would | I have been realized from patients liable | e for payment for services o | n a chargebasis | 0 | 1 |
| nad such payment | peen made in accordance with 42 CFR 413.1 To line 16 (not to exceed 1.000000) | 13(e) | | , | |
| O Total customary c | narges (see instructions) | | | 0.000000 | 1 |
| 00 Excess of customa | ry charges over reasonable cost (complete | e only if line 18 exceeds li | ne 11) (see | 0 | |
| instructions) | | | | 0 | 19 |
| 00 Excess of reasonal | ole cost over customary charges (complete | e only if line 11 exceeds li | ne 18) (see | 0 | 20 |
| instructions) Usesser of cost or | charges (line 11 minus line 20) (for CAH | U coo imakuwati | | | |
| O Interns and reside | ents (see instructions) | H see instructions) | | 5,668,455 | |
| O Cost of teaching p | physicians (see instructions, 42 CFR 415. | .160 and CMS Pub. 15-1, sect | ion 2148) | 0 | _ |
| U Total prospective | payment (sum of lines 3, 4, 8 and 9) | | | ŏ | 1 |
| O Deductibles and co | MBURSEMENT SETTLEMENT insurance (for CAH, see instructions) | | | |] |
| O Deductibles and Co | pinsurance relating to amount on line 24 | (for CAH son instructions) | | 18,650 | |
| O Subtotal {(lines ? | 21 and 24 - the sum of lines 25 and 26) p | plus the sum of lines 22 and | 23) (for CAH | 3,017,867 2,631,938 | 26 27 |
| (See instructions) | | | , (, | 2,031,330 | " |
| O ESRD direct medica | dical education payments (from worksheet I education costs (from worksheet E-4, l | t E-4, line 50) | | 0 | 28 |
| 0 Subtotal (sum of | ines 27 through 29) | 11ne 36) | | 0 | |
| O Primary payer paym | ents | | | 2,631,938 | 1 |
| O Subtotal (line 30 | minus line 31) | | | 1,503 2,630,435 | 1 . |
| ALLOWABLE BAD DEBT | S (EXCLUDE BAD DEBTS FOR PROFESSIONAL SE | RVICES) | | 2,000,100 | - 72 |
| O Allowable had debt | D (from Worksheet I-5, line 11) s (see instructions) | | | 0 | |
| O Adjusted reimbursa | ble bad debts (see instructions) | | | 385,866 | |
| 0 Allowable bad debt | s for dual eligible beneficiaries (see i | instructions) | | 385,866 0 | 35 |
| U Subtotal (sum of 1 | ines 32, 33, and 34 or 35) (line 35 hosp | oital and subprovider only) | | 3,016,301 | |
| U MSP-LCC reconcilia | tion amount from PS&R | · | | 0 | 38 |
| 8 AB Re-billing demo | (SEE INSTRUCTIONS) (SPECIFY) amount (see instructions) | | | 0 | 39 |
| RECOVERY OF ACCELE | RATED DEPRECIATION | | | 0 | 39. |
| O Subtotal (line 37 | plus or minus lines 39 minus 38) | | | 0 3,016,301 | 39. 40. |
| O Interim payments | | | | 3,371,252 | |
| O Ralance due provid | nt (for contractors use only) | | | , , , , 0 | 1 |
| O Protested amounts | er/program (line 40 minus the sum of lin (nonallowable cost report items) in acco | nes 41, and 42) | | -354,951 | |
| IN BE COMPLETED BY | CUNTRACTOR | ordance with CMS Pub. 15-11, | section 115.2 | 0 | 44. |
| O Original outlier a | mount (see instructions) | | | 0 | 90. |
| O Outlier reconcilia | tion adiustment amount (see instruction | ıs) | | 0 | 90. |
| O Time value of Mone | alculate the Time Value of Money | | | 0.00 | |
| O Total (sum of line | , (see instructions) s 91 and 93) | | | 0 | 93. |
| | | | | 0 | 94. |
| | | | - | Overrides 1.00 | |
| WORKSHEET OVERRIDE | VALUES | | | 1.00 | |

| Table Part B mm/dd/yyyy Amount mm/dd/yyyy Amount mm/dd/yyyy Amount mm/dd/yyyy Amount mm/dd/yyyy Amount mm/dd/yyyy Amount mm/dd/yyyy Amount mm/dd/yyyy Amount 1.00 2.00 3.00 4.00 2.00 3.00 4.00 2.00 3.00 4.00 2.00 3.00 4.00 2.00 3.00 4.00 2.00 3.00 4.00 2.00 3.00 4.00 2.00 3.0 | | | Titl | e XVIII | Hospital | 3/29/2013 8:0 Cost | o am |
|---|------|--|--------------|-----------|---------------------------------------|--|----------|
| 1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 | | The state of the s | | | | The second secon | 1 |
| 1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 | | | | | | | |
| 1.00 | | | | | | A THE RESERVE OF THE PARTY OF T | |
| Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NoNE" or neter a zero | 1.00 | Total interim nayments paid to provider | 1.00 | | | | <u> </u> |
| Submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NoNE" or enter a zero | | Interim payments payable on individual hills either | | 2,005,059 | | | |
| Services rendered in the Cost reporting period. If none, write "NoNE" or enter a zero 10 | | submitted or to be submitted to the contractor for | | U | | " | 2.00 |
| 3.00 write "NONE" or enter a zero amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider ADUSTMENTS TO PROGRAM 0 0 0 3.0 | | services rendered in the cost reporting period. If none. | | | | | |
| amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "None" or enter a zero. (1) Program to Provider 3.01 3.02 3.03 3.03 3.04 3.05 8.05 8.07 8.08 8.09 8.09 8.00 8.00 8.00 8.00 8.00 | | write "NONE" or enter a zero | | | | | |
| amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "None" or enter a zero. (1) Program to Provider 3.01 3.02 3.03 3.03 3.04 3.05 8.05 8.07 8.08 8.09 8.09 8.00 8.00 8.00 8.00 8.00 | 3.00 | List separately each retroactive lump sum adjustment | | | | | 3 00 |
| For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) | | amount based on subsequent revision of the interim rate | | | | | 3.00 |
| Program to Provider | | for the cost reporting period. Also show date of each | | | | | |
| ADJUSTMENTS TO PROVIDER | | payment. If none, write "NONE" or enter a zero. (1) | | | | | |
| 3.03 3.03 3.04 3.06 3.07 3.07 3.07 3.08 3.09 | 2 04 | | | | | | |
| 3.04 0 0 0 3.0 3.05 0 0 0 0 3.0 3.06 0 0 0 3.0 3.07 0 0 0 3.0 3.08 0 0 0 3.0 3.09 0 0 3.0 3.50 3.51 0 0 0 3.51 3.52 0 0 0 3.53 3.54 0 0 0 3.54 3.59 3.50 3.50 3.59 3.50 3.50 3.59 3.50 3.50 3.50 3.50 3.50 | | ADJUSTMENTS TO PROVIDER | 10/01/2012 | 270,900 | | 0 | 3.01 |
| 3.05 | | | | 0 | | 0 | 3.02 |
| 3.05 Provider to Program | | | | - | | 0 | 3.03 |
| Provider to Program | | | | | | 0 | 3.04 |
| ADJUSTMENTS TO PROGRAM | 3.03 | | | 0 | | 0 | 3.05 |
| 3.51 0 0 3.53 3.53 0 0 3.53 3.53 0 0 3.53 3.53 0 0 0 3.53 3.53 0 0 0 3.53 3.53 3.59 3.50 3.98 3.50 3.98 3.50 3.98 3.50 3.98 3.50 3.98 3.50 3.98 3.50 3.98 3.50 3.98 3.50 3.98 3.50 3.98 3.50 3.98 3.50 3.98 3.50 3.98 3.50 3.98 3.50 3.98 3.50 3.99 3.371,252 4.00 3.50 3.50 3.98 3.371,252 4.00 3.50 3.50 3.98 3.371,252 4.00 3.50 3.50 3.98 3.371,252 4.00 3.50 3.50 3.50 3.98 3.371,252 4.00 3.50 | 3 50 | | | | | | |
| 3.52 0 | | ADJUSTMENTS TO PROGRAM | | - | | 0 | 3.50 |
| 3.53 3.54 3.59 5.00 3.50 3.50 3.98 3.50 | | | | - | | 1 | 7.71 |
| 3.54 3.99 3.90 3.90 3.90 3.50 3.90 3.90 3.50 3.90 3.90 3.50 3.90 3.50 3.90 3.90 3.90 3.50 3.90 | | | | • | | 1 | |
| Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 3.50-3.98) 3.50-3.98) 3.50-3.98) 3.50-3.98) 3.50-3.98) 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2,935,959 3,371,252 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2,935,959 3,371,252 4.00 | | | | 0 | | | 3.33 |
| 3.50-3.98 3.371,252 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR | | Subtotal (sum of lines 3 01-3 40 minus sum of lines | | 270 000 | | | 3.37 |
| Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR | 3.33 | 3.50-3.98) | | 270,900 | | 0 | 3.99 |
| Ctransfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR | 4.00 | | | 2 025 050 | | 2 274 252 | |
| Appropriate TO BE COMPLETED BY CONTRACTOR | | (transfer to Wkst. E or Wkst. E-3. line and column as | | 2,933,939 | | 3,3/1,252 | 4.00 |
| List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) | | appropriate) | | | | | |
| List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) | | TO BE COMPLETED BY CONTRACTOR | h | | | 1 | |
| desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) | 5.00 | List separately each tentative settlement nayment after | | | | T | 5 00 |
| ##ITLE "NONE" or enter a zero. (1) Program to Provider TENTATIVE TO PROVIDER 0 0 0 0 5.02 | | desk review. Also show date of each payment. If none, | | | | | 3.00 |
| TENTATIVE TO PROVIDER | | write "NONE" or enter a zero. (1) | | | | | |
| Solid column | F 01 | | | | | | |
| Provider to Program | | TENTATIVE TO PROVIDER | | | | 0 | 5.01 |
| Provider to Program | | | | | | 0 | 5.02 |
| TENTATIVE TO PROGRAM 0 0 5.55 | 3.03 | Browiden to Brown | | 0 | | 0 | 5.03 |
| 5.51 5.52 5.52 5.59 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0 0 0 6.01 SETTLEMENT TO PROGRAM 261,932 354,951 6.02 7.00 Total Medicare program liability (see instructions) 2,674,027 3,016,301 7.00 Total Medicare program liability (see instructions) 0 1.00 2.00 | 5 50 | | _ | | | | |
| Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.552 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) | | TENTATIVE TO PROGRAM | | -1 | | 0 | 5.50 |
| 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0 0 0 6.01 6.02 SETTLEMENT TO PROGRAM 261,932 354,951 6.02 7.00 Total Medicare program liability (see instructions) 2,674,027 3,016,301 7.00 Contractor Number (Mo/Day/Yr) 8.00 Name of Contractor 0 1.00 2.00 | | | | - | | 0 | 5.51 |
| 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 8.00 Name of Contractor 0 1.00 2.00 | | Subtotal (sum of lines 5 01-5 49 minus sum of lines | | 0 | | 1 | 5.52 |
| 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 8.00 Name of Contractor 0 1.00 2.00 | | 5.50-5.98) | | 0 | | 0 | 5.99 |
| the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 8.00 Name of Contractor 0 1.00 2.00 | 6.00 | | | | | | _ |
| 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 8.00 Name of Contractor 0 1.00 2.00 | | the cost report. (1) | | | | | 6.00 |
| 261,932 354,951 6.02 7.00 Total Medicare program liability (see instructions) 2,674,027 3,016,301 7.00 | 6.01 | | | n | | | C 0- |
| 7.00 Total Medicare program liability (see instructions) 2,674,027 3,016,301 7.00 | 6.02 | | | 261 022 | | 1 7 | |
| Contractor Date Mumber (Mo/Day/Yr) | 7.00 | Total Medicare program liability (see instructions) | | | | | |
| 8.00 Name of Contractor 0 1.00 2.00 | | | | 2,07.,027 | Contractor | | 7.00 |
| 8.00 Name of Contractor 0 1.00 2.00 | | | | | | | |
| 8.00 Name of Contractor | 0.00 | | 0 | | | | |
| | 6.00 | Name of Contractor | | | · · · · · · · · · · · · · · · · · · · | | 8.00 |

| | | Component | CCN: 152310 10 | 12/31/2012 | Date/Time Pr 5/29/2013 8: | | |
|------|--|------------|----------------|---------------|--------------------------------|--------|-----|
| | | | | ing Beds - SN | | | |
| | | Inpatien | t Part A | Pa | rt B | | |
| | | mm/dd/yyyy | Amount | mm/dd/yyyy | Amount | + | - |
| | | 1.00 | 2.00 | 3.00 | 4.00 | \top | - |
| .00 | Total interim payments paid to provider | | 297,929 | | 1 | 0 | 1.0 |
| .00 | Interim payments payable on individual bills, either | | 0 | | | 0 | 2.0 |
| | submitted or to be submitted to the contractor for | | | | | | |
| | services rendered in the cost reporting period. If none, | | | | | | |
| | write "NONE" or enter a zero | | | | | | |
| .00 | List separately each retroactive lump sum adjustment | | | | | | 3. |
| | amount based on subsequent revision of the interim rate | | | | | - ! | |
| | for the cost reporting period. Also show date of each | | | | | ì | |
| | payment. If none, write "NONE" or enter a zero. (1) | | | | | | |
| | Program to Provider | | | | | | |
| .01 | ADJUSTMENTS TO PROVIDER | 10/01/2012 | 34,900 | | | 0 | 3. |
| .02 | | | 0 | | | 0 | 3. |
| .03 | | | 0 | | | 0 | 3. |
| .04 | | | 0 | | | 0 | 3. |
| .05 | | | 0 | | | 0 | 3. |
| | Provider to Program | | | | | 7 | |
| . 50 | ADJUSTMENTS TO PROGRAM | | 0 | | | 0 | 3. |
| 51 | | | 0 | | | 0 | 3. |
| 52 | | | 0 | | 1 | 0 | 3. |
| 53 | | | 0 | | 1 | 0 | 3. |
| . 54 | | | 0 | | 1 | 0 | 3. |
| . 99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines | | 34,900 | | | 0 | 3. |
| | 3.50-3.98) | | • | | | | ٠. |
| .00 | Total interim payments (sum of lines 1, 2, and 3.99) | | 332,829 | | 1 | οĺ | 4. |
| | (transfer to Wkst. E or Wkst. E-3, line and column as | | , i | | | Ī | |
| | appropriate) | | | | | | |
| | TO BE COMPLETED BY CONTRACTOR | | | | | ٦ | |
| .00 | List separately each tentative settlement payment after | | | | | | 5. |
| | desk review. Also show date of each payment. If none, | | | | | | |
| | write "NONE" or enter a zero. (1) | | | | | | |
| | Program to Provider | | | | | 7 | |
| .01 | TENTATIVE TO PROVIDER | | 0 | | 1 | 0 | 5. |
| .02 | | | 0 | | (| 0 | 5. |
| .03 | | | 0 | | (| 0 | 5. |
| | Provider to Program | | | | | ٦ | |
| 50 | TENTATIVE TO PROGRAM | | 0 | | 1 | 0 | 5. |
| 51 | | | 0 | | (| 0 | 5. |
| 52 | | | 0 | | 1. (| 0 | 5. |
| .99 | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) | | 0 | | | 0 | 5. |
| 00 | Determined net settlement amount (balance due) based on the cost report. (1) | | | | | | 6. |
| 01 | SETTLEMENT TO PROVIDER | | 0 | | 1 | o | 6. |
| .02 | SETTLEMENT TO PROGRAM | | 28,332 | | | ŏ | 6. |
| 00 | Total Medicare program liability (see instructions) | | 304,497 | | | o l | 7. |
| | | | | Contractor | Date | + | |
| | | |] | Number | (Mo/Day/Yr) | | |
| | | 0 | | 1.00 | 2.00 | \top | |
| .00 | Name of Contractor | | | | | + | 8. |
| | | | | | | | |

| onent CCN: 155365 | To 12/31/2012 | Date/Time Prepared: 5/29/2013 8:08 am |
|-------------------|-----------------|---------------------------------------|
| Title XVIII | Skilled Nursing | PPS |

| | | Component | CCN: 155365 | | Part I Date/Time Prep 5/29/2013 8:08 | |
|----------|---|------------|-------------|-----------------------------|--|-----|
| | | Title | e XVIII | Skilled Nursing Facility | PPS | |
| | | Inpatien | t Part A | Par | t B | |
| | | mm/dd/yyyy | Amount | mm/dd/yyyy | Amount | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | |
| .00 | Total interim payments paid to provider | | 205,3 | | 0 | 1.0 |
| .00 | Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero | | | 0 | 0 | 2. |
| .00 | List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider | | | | | 3. |
| .01 | ADJUSTMENTS TO PROVIDER | | | 0 | 0 | 3. |
| . 02 | ADJUSTINENTS TO TROVEDER | | | 0 | 0 | 3. |
| . 03 | | | | 0 | 0 | 3. |
| .04 | | | | 0 | .0 | 3. |
| .05 | | | | 0 | 0 | 3 |
| | Provider to Program | | | | | |
| 50 | ADJUSTMENTS TO PROGRAM | | | 0 | 0 | 3 |
| 51 | | | | 0 | 0 | 3 |
| 52 | | | | 0 | 0 | , - |
| 53 | | | | 0 | 0 | 3 |
| 54 | | | | 0 | 0 | 3 |
| 99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) | | | 0 | 0 | 3 |
| 00 | Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) | | 205,3 | 61 | 0 | 4 |
| 00 | TO BE COMPLETED BY CONTRACTOR | T | r | | | _ |
| .00 | List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) | | | | | 5 |
| | Program to Provider | , | | | | |
| 01 | TENTATIVE TO PROVIDER | | | 0 | 0 | |
| 02 | | | | 0 | 0 | - |
| 03 | | L | <u></u> | | 0 | 5 |
| EΩ | Provider to Program TENTATIVE TO PROGRAM | Т | | 0 | 0 | 5 |
| 50 51 | TENTALIVE TO PROGRAM | | | 0 | 0 | |
| 52 | | | | 0 | 0 | 1 - |
| 99 | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) | ! | | o | ő | 1 - |
| 00 | Determined net settlement amount (balance due) based on the cost report. (1) | | | | | 6 |
| 01 | SETTLEMENT TO PROVIDER | | | 0 | 0 | 6 |
| 02 | SETTLEMENT TO PROGRAM | | | O | 0 | 1 |
| 00 | Total Medicare program liability (see instructions) | | 205,3 | 361 | 0 | 7 |
| | | | | Contractor Number | Date (Mo/Day/Yr) | |
| .00 | Name of Contractor | |) | 1.00 | 2.00 | 8 |

| CALCUI | ATION OF REIMBURSEMENT SETTLEMENT FOR HIT | Provider CCN: 151310 | | u of Form CMS- | |
|-------------|--|--------------------------------|--|----------------|----------|
| | SETTLEMENT TON HET | Provider CCN: 131310 | Period: From 01/01/2012 | Worksheet E-1 | |
| | | | To 12/31/2012 | | narod: |
| | | | 10 12/31/2012 | 5/29/2013 8:0 | 8 am |
| *** | | Title XVIII | Hospital | Cost | <u> </u> |
| | | | | | |
| nitronitani | TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REP | | | 1.00 | |
| | HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCU | 'UKIS | | | |
| 1.00 | Total hospital discharges as defined in AARA §4102 from | m West 5.2 Part T column 15 li | no 14 | 673 | |
| 2.00 | Medicare days from Wkst S-3, Part I, column 6 sum of 1 | inos 1 9 17 | ne 14 | 672 | |
| 3.00 | Medicare HMO days from Wkst S-3, Part I, column 6. line | 0.7 | | 1,202 | |
| 4.00 | Total inpatient days from S-3, Part I column 8 sum of | 1 ince 1 0 12 | | 445 | |
| 5.00 | Total hospital charges from Wkst C, Part I, column 8 1 | ino 200 | | 2,265 | |
| 6.00 | Total hospital charity care charges from Wkst S-10, col | lumn 2 line 20 | | 77,989,688 | |
| 7.00 | CAH only - The reasonable cost incurred for the purchase | so of contified UTT technology | \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ | 1,915,383 | l . |
| | Part I line 168 | se or certified Hir technology | worksneet S-2, | 1,017,880 | 7.00 |
| 8.00 | Calculation of the HIT incentive payment (see instructi | ions) | | 062 402 | 9.00 |
| | INPATIENT HOSPITAL SERVICES UNDER PPS & CAH | | | 962,493 | 8.00 |
| 30.00 | Initial/interim HIT payment adjustment (see instruction | ns) | | 872,527 | 30.00 |
| 31.00 | Other Adjustment (specify) | | | 0/2,32/ | |
| 32.00 | Balance due provider (line 8 minus line 30 and line 31) |) | | 89,966 | |
| | A Company of the Comp | | Control Statement Control and the Control of the Co | Overrides | 32.00 |
| | The contract of the contract o | | | 1.00 | |
| | CONTRACTOR OVERRIDES | | | | |
| 108.00 | Override of HIT payment | | | 0 | 108.00 |

| CALCU | Financial Systems WABASH COUNTY HOS ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | | | u of Form CMS- | 2552- |
|--------|--|-----------------------|----------------------------------|--------------------------------|------------|
| | A WATER OF STATE OF THE PRINT - SMING REDS | Provider CCN: 151310 | Period: | Worksheet E-2 | |
| | | Component CCN: 15Z310 | From 01/01/2012 To 12/31/2012 | Date/Time Pre 5/29/2013 8:0 | pared |
| | | Title XVIII | Swing Beds - SNF | Cost | O am |
| | | | Part A | Part B | T |
| | COMPUTATION OF NET COST OF COVERED SERVICES | | 1.00 | 2.00 | |
| 1.00 | Inpatient routine services - swing bed-SNF (see instructions) | | | | |
| .00 | Impatient routine services - swing had we (see instructions) | | 218,933 | 0 | 1.0 |
| .00 | AUCTITATY SERVICES (Trom Wkst. D-3 column 3 line 200 for part | | | | 2.0 |
| | | | , 90,044 | 0 | 3.0 |
| .00 | is a demicost for interns and residents not in approved toaching | nrogram (soo | | | |
| 0.0 | mscructions) | program (see | | 0.00 | 4.0 |
| .00 | Program days | | 178 | 0 | |
| .00 | Interns and residents not in approved teaching program (see inst | ructions) | 170 | 0 | 5. |
| .00 | ocilization review - physician compensation - she optional matha | d only | 0 | ٥ | 6. |
| .00 | Subtotal (Sum of Times I through 3 hins lines 6 and 7) | • | 308,977 | ol | 7.0 8.0 |
| 0.00 | Primary payer payments (see instructions) | | 300,377 | 0 | 9.0 |
| | Subtotal (line 8 minus line 9) | | 308,977 | 0 | |
| 1.00 | Deductibles billed to program patients (exclude amounts applicab professional services) | le to physician | 0 | 0 | 11.0 |
| | Subtotal (line 10 minus line 11) | | | ٥ | 41.0 |
| 3.00 | Coinsurance hilled to program nationts (form | | 308,977 | 0 | 12.0 |
| | Coinsurance billed to program patients (from provider records) (for physician professional services) | exclude coinsurance | 4,480 | | 13.0 |
| 4.00 | 80% of Part B costs (line 12 x 80%) | | | | |
| 5.00 | Subtotal (enter the lesser of line 12 minus line 12 on line 14) | | | 0 | 14.0 |
| J. 00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIEV) | | 304,497 | 0 | 15.0 |
| '.UU | Reimbursable bad debts (see instructions) | | 0 | 0 | 16.0 |
| s.00 j | Reimbursable bad debts for dual eligible beneficiaries (see inch. | cuctions) | 0 | | 17.0 |
| .00 | rocar (sum of fines 15 and 17, plus/minus line 16) | decrons) | 304 407 | 1 | 18.0 |
| .00 | Interim payments | | 304,497 | | 19.0 |
| .00 | Tentative settlement (for contractor use only) | | 332,829 | | 20.0 |
| .00 | Balance due provider/program (lino 10 minus +b 6 2: | and 21) | -28,332 | | 21.0 |
| | rocested amounts (nonallowable cost report items) in accordance | with CMS Pub. 15-TT | -20,332 | | 22.0 |
| İ | section 115.2 | 5.5 . 45. 15 11, | U | 0 | 23.0 |

| | Financial Systems WABASH COUNTY ATION OF REIMBURSEMENT SETTLEMENT | | | u of Form CMS- | |
|-------|--|--|---|----------------|--------|
| | ATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 151310 | Period: From 01/01/2012 To 12/31/2012 | | pared: |
| | A CONTROL OF THE PROPERTY OF T | Title XVIII | Hospital | Cost | |
| | | | | | |
| | PART V - CALCULATION OF RETURNING FUEL CITES CHEEK FOR MEDICAL | | | 1.00 | |
| 1.00 | PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICAF Inpatient services | CE PART A SERVICES - COST | REIMBURSEMENT (C | AHS) | 1 |
| 2.00 | Nursing and Allied Health Managed Care payment (see instruc- | +-i.n) | | 2,913,642 | |
| 3.00 | Organ acquisition | cion) | | 0 | 2.0 |
| 4.00 | Subtotal (sum of lines 1 thru 3) | | | 0 | |
| 5.00 | Primary payer payments | | | 2,913,642 | |
| 6.00 | Total cost (line 4 less line 5). For CAH (see instructions) | | | 3,387 | 1 |
| | COMPUTATION OF LESSER OF COST OR CHARGES | | | 2,939,391 | 6.00 |
| | Reasonable charges | | | | |
| 7.00 | Routine service charges | | | 0 | 7.00 |
| 8.00 | Ancillary service charges | | | 0 | |
| 9.00 | Organ acquisition charges, net of revenue | | | 0 | |
| 10.00 | Total reasonable charges | | | • | 10.00 |
| | Customary charges | -12 VI // // VI -12 VI // VI -12 VI // VI -12 VI -1 | | | 10.00 |
| 11.00 | Aggregate amount actually collected from patients liable for | r payment for services on | a charge basis | 0 | 11.00 |
| 12.00 | AMOUNTS that would have been realized from nationts liable t | for navment for convices o | n a charge basis | Ö | 12.00 |
| | indu such payment been made in accordance with 42 CFR 413 130 | (e) | | · · | 12.00 |
| 13.00 | Ratio of line 11 to line 12 (not to exceed 1.000000) | | | 0.000000 | 13.00 |
| 15 00 | Total customary charges (see instructions) | | | 0 | |
| 13.00 | Excess of customary charges over reasonable cost (complete cinstructions) | only if line 14 exceeds li | ne 6) (see | 0 | 15.00 |
| 16.00 | Excess of reasonable cost over customary charges (complete o | | | | |
| | instructions) | only it line b exceeds lin | e 14) (see | 0 | 16.00 |
| 17.00 | Cost of teaching physicians (from Worksheet D-5, Part II, co | nlumn 3 line 20) (see ins | tructions) | | 17.00 |
| | COMPUTATION OF REIMBURSEMENT SETTLEMENT | Traini 3, Trile 207 (See Ths | cructions) | | 17.00 |
| 18.00 | Direct graduate medical education payments (from worksheet F | -4. line 49) | | | 10.00 |
| 19.00 | Cost of covered services (sum of lines 6. 17 and 18) | - 1, 11110 137 | 1 | 2,939,391 | 18.00 |
| 20.00 | Deductibles (exclude professional component) | | | 286,688 | |
| 21.00 | | | | 200,000 | |
| 22.00 | Subtotal (line 19 minus line 20) | | | 2,652,703 | |
| | Coinsurance | | | | 23.00 |
| 24.00 | Subtotal (line 22 minus line 23) | | | 2,652,414 | |
| 25.00 | Allowable bad debts (exclude bad debts for professional serv | vices) (see instructions) | | 21,613 | |
| 20.00 | Adjusted reimbursable bad debts (see instructions) | | | 21,613 | |
| 28.00 | Allowable bad debts for dual eligible beneficiaries (see ins | structions) | | o | 27.00 |
| 29.00 | Subtotal (sum of lines 24 and 25, or line 26) | | | 2,674,027 | 28.00 |
| 29.99 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Recovery of Accelerated Depreciation | | | 0 | |
| 30.00 | Subtotal (line 28, plus or minus lines 29) | | | 0 | 29.99 |
| 31.00 | Interim payments | | | 2,674,027 | |
| | Tentative settlement (for contractor use only) | | | 2,935,959 | 31.00 |
| 33.00 | Balance due provider/program (line 30 minus the sum of lines | 21 1 223 | | 0 | 32.00 |
| 34.00 | Protested amounts (nonallowable cost report items) in accord | is 31, and 32) | | -261,932 | |
| 1 | amounts (nonarionable cost report rems) in accord | nance with CMS Pub. 15-2, | section 115.2 | 0 | 34.00 |

| CALCU | ATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 151310 | Period: | u of Form CMS- Worksheet E-3 | |
|----------------|--|------------------------------|-----------------------------|---------------------------------|----------------|
| | | | From 01/01/2012 | Part VI | |
| | | Component CCN: 155365 | | Date/Time Pre 5/29/2013 8:0 | pared: 8 am |
| | | Title XVIII | Skilled Nursing Facility | PPS | |
| | | | | 1.00 | |
| | PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL SERVICES | OTHER HEALTH SERVICES FOR T | ITLE XVIII PART A | PPS SNF | |
| | PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS) | | | | - |
| 1.00 | Resource Utilization Group Payment (RUGS) | | | 240,619 | 1.00 |
| 2.00 | Routine service other pass through costs | | | 0 240,013 | 1 |
| 3.00 | Ancillary service other pass through costs | | | ň | 3.0 |
| 4.00 | Subtotal (sum of lines 1 through 3) | | | 240,619 | |
| | COMPUTATION OF NET COST OF COVERED SERVICES | | | 270,013 | 7.0 |
| 5.00 | Medical and other services (Do not use this line as vacci | ne costs are included in lin | e 1 of W/S F | | 5.00 |
| | Part B. This line is now shaded.) | | , , | | 1 3.0 |
| 6.00 | Deductible | | | 0 | 6.00 |
| 7.00 | Coinsurance | | | 35,258 | |
| 8.00 | Allowable bad debts (see instructions) | | | 0 | 8.00 |
| 9.00 | Reimbursable bad debts for dual eligible beneficiaries (s | ee instructions) | | 0 | 9.00 |
| 10.00 | Allowable reimbursable bad debts (see instructions) | | | 0 | 10.00 |
| 11.00 | Utilization review | | | 0 | 11.00 |
| 12.00 | Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(| see Instructions) | | 205,361 | 12.00 |
| 13.00 | Inpatient primary payer payments | | | 0 | 13.00 |
| 14.00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | | 0 | 14.00 |
| 14.99 | Recovery of Accelerated Depreciation | | | 0 | 14.99 |
| 15.00 16.00 | Subtotal (line 12 minus 13 ± lines 14 | | 1 | 205,361 | 15.00 |
| | Interim payments | | | 205,361 | 16.00 |
| 10 00 | Tentative settlement (for contractor use only) | | | 0 | 17.00 |
| 10.00 | Balance due provider/program (line 15 minus the sum of li | nes 16 and 17) | 1 | 0 | 18.00 |
| 19.00 | Protested amounts (nonallowable cost report items) in acco | ordance with CMS 19 Pub. 15- | 2, section 115.2 | 0 | 19.00 |

Health Financial Systems

WABASH COUNTY HOSPITAL

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

WABASH COUNTY HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 151310

Period: From 01/01/2012

| fund | -type accounting records, complete the General Fund column on | ily) | CCN: 121310 | From 01/01/2 | | Worksheet G | |
|----------------|--|------------------------|--------------------------|--------------|------|--------------------------------|------------------|
| | | | | To 12/31/2 | 2012 | Date/Time Pre 5/29/2013 8:0 | epared: 08 am |
| | | General Fund | Specific Purpose Fund | Endowment i | Fund | Plant Fund | 9,111 |
| | CURRENT ASSETS | 1.00 | 2.00 | 3.00 | | 4.00 | |
| 1.00 | Cash on hand in banks | 1 350 063 | | TT | | | |
| 2.00 | Temporary investments | 1,359,963 6,085,124 | | 0 | 0 | 0 | |
| 3.00 | Notes receivable | 0,003,124 | | 0 | 0 | 0 | |
| 4.00 | Accounts receivable | 15,291,692 | | 0 | 0 | 0 | |
| 5.00 | Other receivable | 529,026 | | 0 | 0 | 0 | 1 |
| 6.00 7.00 | Allowances for uncollectible notes and accounts receivable | -8,137,627 | | o | 0 | 0 | |
| 8.00 | Inventory Prepaid expenses | 923,845 | | o | ŏ | 0 | 1 0.00 |
| 9.00 | Other current assets | 200,636 | | 0 | 0 | ő | |
| 10.00 | Due from other funds | 0 | | 0 | 0 | 0 | 1 |
| 11.00 | | 16 353 650 | | 0 | 0 | 0 | 1 |
| | FIXED ASSETS | 16,252,659 | | 0 | 0 | 0 | 11.00 |
| 12.00 | | | | 0 | | | |
| 13.00 | | 0 | | 0 | 0 | 0 | |
| 14.00 | | 0 | | 0 | 0 | 0 | |
| 15.00 | Buildings | 33,798,275 | | ol | 0 | 0 | |
| 17.00 | Accumulated depreciation | -26,256,602 | | o | 0 | 0 | 15.00 16.00 |
| 18.00 | | 0 | | o | 0 | 0 | 17.00 |
| | Fixed equipment | 0 | | 0 | 0 | 0 | 18.00 |
| 20.00 | Accumulated depreciation | 0 | | o | 0 | Ö | 19.00 |
| 21.00 | Automobiles and trucks | 0 | | 0 | 0 | 0 | 20.00 |
| 22.00 | Accumulated depreciation | 0 | | 0 | 0 | 0 | 21.00 |
| 23.00 | Major movable equipment | O O | | 0 | 0 | 0 | 22.00 |
| 24.00 | Accumulated depreciation | 0 | | 0 | 0 | 0 | 23.00 |
| 25.00 | Minor equipment depreciable | 0 | | 3 | 0 | 0 | 24.00 |
| 26.00 | Accumulated depreciation | Ö | | | 0 | 0 | 25.00 |
| 28.00 | HIT designated Assets | o | | | 0 | 0 | 26.00 |
| 29 00 | Accumulated depreciation Minor equipment-nondepreciable | 0 | į. | ol | 0 | 0 | 27.00 28.00 |
| 30.00 | Total fixed assets (sum of lines 12-29) | 0 | (| o | o | ŏ | 29.00 |
| | OTHER ASSETS | 7,541,673 | (| | o | ő | 30.00 |
| | Investments | | | | | | |
| 32.00 | Deposits on leases | 0 | (| | 0 | 0 | 31.00 |
| 33.00 | Due from owners/officers | 0 | (| 2 | 0 | 0 | 32.00 |
| 34.00 | Other assets | 9,479,913 | (| () | 0 | 0 | 33.00 |
| 35.00 | Total other assets (sum of lines 31-34) | 9,479,913 | . (| | 0 | 0 | 34.00 |
| 30.00 | Total assets (sum of lines 11, 30, and 35) | 33,274,245 | Ò | 1 | 0 | 0 | 35.00 |
| 37.00 | CURRENT LIABILITIES Accounts payable | | | | | | 36.00 |
| 38.00 | Salaries, wages, and fees payable | 1,085,267 | (| | 0 | 0 | 37.00 |
| 39.00 | Payroll taxes payable | 1,611,387 | C | ĺ | 0 | ŏ | 38.00 |
| 40.00 | Notes and loans payable (short term) | 0 | C | | o | 0 | 39.00 |
| 41.00 | Deferred income | 0 | C | | 0 | o | 40.00 |
| 42.00 | Accelerated payments | U | C | | 0 | 0 | 41.00 |
| 43.00 | Due to other funds | 360,503 | ^ | | | | 42.00 |
| 44.00 45.00 | Other current liabilities | 446,263 | 0 | 1 | 0 | | 43.00 |
| 43.00 | Total current liabilities (sum of lines 37 thru 44) | 3,503,420 | 0 | | 0 | | 44.00 |
| 46.00 | LONG TERM LIABILITIES Mortgage payable | | | I | | 0 | 45.00 |
| | Notes payable | 115,621 | 0 | | 0 | 0 | 46.00 |
| | Unsecured loans | 0 | 0 | | 0 | | 47.00 |
| 19.00 | Other long term liabilities | 0 | 0 | | 0 | 1 | 48.00 |
| 0.00 | Total long term liabilities (sum of lines 46 thrus 40 | 0 | 0 | | 0 | | 49.00 |
| 1.00 | Total Habilites (sum of lines 45 and 50) | 115,621 | 0 | | 0 | | 50.00 |
| ļ | CAPITAL ACCOUNTS | 3,619,041 | 0 | | 0 | i | 51.00 |
| | General fund balance | 29,655,204 | | | | | |
| 3.00 | Specific purpose fund | -5,055,204 | 0 | | | 1 | 52.00 |
| 4.00 5.00 | Donor created - endowment fund balance - restricted | | U | | | | 53.00 |
| 13.00 | bonor created - endowment fund balance - unrostricted | | | | 0 | | 54.00 |
| 0.00 | Governing body created - endowment fund balance Plant fund balance - invested in plant | | | | 0 | | 55.00 |
| 8.00 | Plant fund balance - reserve for plant improvement, | | | | ٦ | | 56.00 57.00 |
| | repracement, and expansion | | | | | | 57.00 58.00 |
| 9.00 | Total fund balances (sum of lines 52 they 50) | 30 655 55 | | | | 3 | 55.00 |
| 0.00 | lotal Habilities and fund balances (sum of lines 51 and | 29,655,204 | 0 | | 0 | 0 5 | 59.00 |
| | 59) | 33,274,245 | 0 | | 0 | | 60.00 |
| | ı | I | ļ | | 1 | | - |

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19.00

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9.00

10.00

11.00

12.00

13.00

14.00

15.00

16.00

17.00

18.00

Total additions (sum of line 4-9)

Deductions (debit adjustments) (specify)

Total deductions (sum of lines 12-17)

Fund balance at end of period per balance

Subtotal (line 3 plus line 10)

sheet (line 11 minus line 18)

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151310

Period: Worksheet G-2 From 01/01/2012 Parts I & II

12/31/2012 Date/Time Prepared: 5/29/2013 8:08 am Cost Center Description Inpatient Outpatient Total 1.00 2.00 3.00 PART I - PATIENT REVENUES General Inpatient Routine Services 1.00 Hospital 4,988,845 4,988,845 1.00 2.00 SUBPROVIDER - IPF 2.00 SUBPROVIDER - IRF 3.00 3.00 4.00 SUBPROVIDER 4.00 5.00 Swing bed - SNF 0 5.00 6.00 Swing bed - NF 0 6.00 7.00 SKILLED NURSING FACILITY 1,276,174 1,276,174 7.00 8.00 NURSING FACILITY 8.00 9.00 OTHER LONG TERM CARE 9.00 10.00 Total general inpatient care services (sum of lines 1-9) 6,265,019 6,265,019 10.00 Intensive Care Type Inpatient Hospital Services 11.00 INTENSIVE CARE UNIT 11.00 12.00 CORONARY CARE UNIT 12.00 13.00 BURN INTENSIVE CARE UNIT 13.00 14.00 SURGICAL INTENSIVE CARE UNIT 14.00 15.00 OTHER SPECIAL CARE (SPECIFY) 15.00 16.00 Total intensive care type inpatient hospital services (sum of lines 0 16.00 11-15) 17.00 Total inpatient routine care services (sum of lines 10 and 16) 6,265,019 6,265,019 17.00 Ancillary services 18.00 11,506,548 57,748,084 69,254,632 18.00 19.00 Outpatient services 5,040 122,093 127,133 19.00 20.00 RURAL HEALTH CLINIC 0 20.00 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 21.00 22.00 HOME HEALTH AGENCY 1,249,441 1,249,441 22.00 23.00 AMBULANCE SERVICES 23.00 24.00 CMHC 24,00 25.00 AMBULATORY SURGICAL CENTER (D.P.) 25.00 26.00 HOSPICE 1,220,593 1,220,593 26.00 27.00 OTHER (SPECIFY) 27.00 28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 17,776,607 60,340,211 78,116,818 28.00 G-3, line 1) PART II - OPERATING EXPENSES 29.00 Operating expenses (per wkst. A, column 3, line 200) 40,197,371 29.00 30.00 ADD (SPECIFY) 0 30.00 31.00 0 31.00 32.00 0 32.00 33.00 33.00 34.00 0 34.00 35.00 35.00 36.00 Total additions (sum of lines 30-35) 36.00 37.00 DEDUCT (SPECIFY) 7,829,512 37.00 38.00 88,195 38.00 39.00 0 39.00 40.00 0 40.00 41.00 0 41.00 Total deductions (sum of lines 37-41) 42.00 7,917,707 42.00 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 32,279,664 43.00

to Wkst. G-3, line 4)

| STATE | MENT OF REVENUES AND EXPENSES | Provider CCN: 151310 | Period: | Worksheet G-3 | |
|-------|---|--|----------------------------------|--------------------------------|----------------|
| | | | From 01/01/2012 To 12/31/2012 | Date/Time Pre 5/29/2013 8:0 | pared: 8 am |
| | | | | 1 00 | |
| 1.00 | Total patient revenues (from Wkst. G-2, Part I, column 3, line | 28) | | 1.00 78,116,818 | 1.00 |
| 2.00 | Less contractual allowances and discounts on patients' accounts | | Į. | 43,053,264 | 1 |
| 3.00 | Net patient revenues (line 1 minus line 2) | | | 35,063,554 | |
| 4.00 | Less total operating expenses (from Wkst. G-2, Part II, line 43 | D. | | 32,279,664 | |
| 5.00 | Net income from service to patients (line 3 minus line 4) | , | | 2,783,890 | |
| | OTHER INCOME | and the second section of the second section of the second section of the second sections and the second section of the section of the second section of the second section of the second section of the second section of the second section of the second section of the second section of the second section of the second section of the second section of the second section of the section of the second section of the second section of the second section of the second section of the second section of the second section of the second section of the second section of the sec | | 2,703,030 | 3.00 |
| 6.00 | Contributions, donations, bequests, etc | | | 0 | 6.00 |
| 7.00 | Income from investments | | | Ö | 1 |
| 8.00 | Revenues from telephone and telegraph service | | | 0 | |
| 9.00 | Revenue from television and radio service | | | ō | 1 |
| 10.00 | | | | Õ | |
| 11.00 | Rebates and refunds of expenses | | | Ö | |
| | Parking lot receipts | | | 0 | |
| 13.00 | Revenue from laundry and linen service | | | 0 | |
| 14.00 | Revenue from meals sold to employees and guests | | | 0 | 14.00 |
| 15.00 | Revenue from rental of living quarters | | | 0 | 15.00 |
| 16.00 | Revenue from sale of medical and surgical supplies to other tha | n patients | | 0 | 16.00 |
| 17.00 | Revenue from sale of drugs to other than patients | | | 0 | 17.00 |
| 18.00 | Revenue from sale of medical records and abstracts | | | 0 | 18.00 |
| 19.00 | Tuition (fees, sale of textbooks, uniforms, etc.) | | | 0 | 19.00 |
| 20.00 | Revenue from gifts, flowers, coffee shops, and canteen | | | 0 | 20.00 |
| 22.00 | Rental of vending machines | | | 0 | 21.00 |
| 23.00 | Rental of hospital space | | | 0 | 22.00 |
| | Governmental appropriations OTHER (SPECIFY) | | | 0 | 23.00 |
| 25.00 | Total other income (sum of lines 6-24) | | | 1,116,586 | |
| 26.00 | Total (line 5 plus line 25) | | | 1,116,586 | |
| | OTHER EXPENSES (SPECIFY) | | | 3,900,476 | |
| | Total other expenses (sum of line 27 and subscripts) | | | 3,354,870 | |
| 29.00 | Net income (or loss) for the period (line 26 minus line 28) | | | 3,354,870 | |
| _3.00 | | • | 1 | 545,606 | 29.00 |

Column, 6 line 24 should agree with the Worksheet A, column 7, line 101, or subscript as applicable.

0

0

54,234

1,364,081

426

54.234

1,364,081

426

21.00

22.00

23.00

24.00

Home Delivered Meals Program

Homemaker Service

All Others (specify)

24.00 | Total (sum of lines 1-23)

22.00

23.00

| .031 | ALLOCATION - HHA GENERAL SERVIC | E COST | | Provider | CCN: 151310 | Period: From 01/01/2012 | Worksheet H-1 Part I | L |
|--|--|--|---------------------|----------------------|--|----------------------------|-------------------------|----------------------|
| | | | | HHA CCN: | 157061 | To 12/31/2012 | | epare 08 am |
| | | | | | | Home Health Agency I | PPS | |
| | | | Capital Rela | ted Costs | ana Alban Parlament namanananjiyaan maanangiyyaniya aa | rigency 1 | | T |
| | | Net Expenses for Cost Allocation (from wkst. H, col. 10) | Bldgs & Fixtures | Movable Equipment | Plant Operation & Maintenance | | Subtotal (cols. 0-4) | - |
| | GENERAL SERVICE COST CENTERS | 0 | 1.00 | 2.00 | 3.00 | 4.00 | 4A.00 | |
| .00 | Capital Related - Bldg. & Fixtures | 0 | 0 | | | | 0 | $\overline{0}$ 1. |
| .00 | Capital Related - Movable | 0 | | 0 | | | 0 | 2. |
| .00 | Equipment Plant Operation & Maintenance | | | | | | Ŭ | 1 - |
| .00 | Transportation | 0 | 0 | 0 | | 0 0 | 0 | |
| .00 | Administrative and General | 205,844 | | ŏ | | 0 0 | 205,844 | 4. |
| . 00 | HHA REIMBURSABLE SERVICES | | | | AT 2 31 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | | |] |
| .00 | Skilled Nursing Care Physical Therapy | 641,316 | 1 | 0 | | 0 0 | 641,316 | |
| .00 | Occupational Therapy | 204,391 35,604 | 0 | 0 | | 0 0 | 204,391 | |
| .00 | Speech Pathology | 10,377 | 0 | 0 | | 0 0 | 35,604 10,377 | |
| 0.00 | | 466 | o | ő | | 0 0 | 466 | 1 |
| 1.00 2.00 | | 211,423 | 0 | 0 | | 0 0 | 211,423 | |
| 3.00 | | 0 | 0 | 0 | | 0 | 0 | |
| 4.00 | 3 | 0 | 0 | 0 | | 0 0 | 0 | 13 |
| | HHA NONREIMBURSABLE SERVICES | | | <u> </u> | | 0 0 | 0 | 14 |
| 5.00 | Home Dialysis Aide Services | 0 | 0 | 0 | . ************************************* | 0 0 | 0 | 15 |
| 6.00 7.00 | Respiratory Therapy Private Duty Nursing | 0 | 0 | 0 | | 0 | 0 | |
| 8.00 | | 0 | 0 | 0 | | 0 | 0 | |
| 9.00 | Health Promotion Activities | Ö | 0 | 0 | | 0 0 | 0 | |
| 0.00 | Day Care Program | ő | ő | 0 | | 0 | 0 | 19 |
| | Home Delivered Meals Program | o | 0 | Ö | | 0 0 | 0 | 1 |
| 2.00 3.00 | | 54,234 | 0 | 0 | | 0 0 | 54,234 | |
| | Total (sum of lines 1-23) | 426 1,364,081 | 0 | 0 | | 0 | | 23 |
| | | Administrative | Total (cols | 0 | | 0 0 | 1,364,081 | 24. |
| | | & General | 4A + 5) | | | | | |
| | GENERAL SERVICE COST CENTERS | 5.00 | 6.00 | | | l | | |
| .00 | Capital Related - Bldg. & Fixtures | | | - | | | | 1. |
| .00 | Capital Related - Movable Equipment | | | | | | | 2. |
| .00 | Plant Operation & Maintenance | | | | | | | י |
| . 00 . 00 | Transportation | | | | | | | 3. 4. |
| . 00 | Administrative and General HHA REIMBURSABLE SERVICES | 205,844 | · | ··· · | | | | 5. |
| .00 | Skilled Nursing Care | 113,974 | 755,290 | | P. I. C | | | _ |
| .00 | Physical Therapy | 36,325 | 240,716 | | | | | 6. |
| .00 | Occupational Therapy | 6,328 | 41,932 | | | | | 7. 8. |
| .00 .00 | Speech Pathology Medical Social Services | 1,844 | 12,221 | | | | | 9. |
| 1.00 | Home Health Aide | 83 37,575 | 549 | | | | | 10. |
| 00.9 | Supplies (see instructions) | 37,375 N | 248,998 | | | | | 11. |
| 3.00 | Drugs | ŏ | 0 | | | | | 12. |
| 1.00 | | 0 | o | | | | | 13. 14. |
| | HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services | | | | | | | 17. |
| 00 | Respiratory Therapy | 0 | 0 | | | - 1 | | 15. |
| .00 | Private Duty Nursing | 0 | 0 0 | | | | | 16. |
| .00 5.00 7.00 | | - 1 | 0 | | | | - | 17. |
| .00 5.00 7.00 8.00 | Clinic | 0 | | | | | | 18. |
| 5.00 5.00 7.00 5.00 | Clinic Health Promotion Activities | 0 | ŏ | | | | | 10 |
| 5.00 5.00 7.00 8.00 9.00 | Clinic Health Promotion Activities Day Care Program | 0 | 0 | | | | | |
| 5.00 7.00 8.00 9.00 9.00 | Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program | 0 0 0 | 0 0 0 | | | | | 19.0 20.0 21.0 |
| 3.00 3.00 3.00 3.00 3.00 3.00 3.00 | Clinic Health Promotion Activities Day Care Program | 0 | 0 | | | | | 20. |

| COST | OST ALLOCATION - HHA STATISTICAL BASIS | | | | CCN: 151310 157061 | Period: From 01/01/2012 To 12/31/2012 | | pared: |
|----------------|--|--------------------------------------|--|-------------|---------------------------|---|--|----------|
| | | | | | | Home Health Agency I | PPS | o am |
| | | Capital Re | lated Costs | | | , , , , , , , , , , , , , , , , , , , | | |
| | | Bldgs & Fixtures (SQUARE FEET) | Movable Equipment (DOLLAR VALUE) | Operation & | Transportati (MILEAGE) | onReconciliation | Administrative & General (ACCUM. COST) | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5A.00 | 5.00 | † |
| | GENERAL SERVICE COST CENTERS | | | | | | | |
| 1.00 | Capital Related - Bldg. & | 0 | | | | 0 | | 1.00 |
| 2.00 | Fixtures Capital Related - Movable Equipment | * | 0 | | | 0 | | 2.00 |
| 3.00 | Plant Operation & Maintenance | 0 | 0 | 0 | | 0 | | 3 00 |
| 4.00 | Transportation (see | 0 | 0 | 0 | | | | 3.00 |
| | instructions) | _ | Ĭ | | | | | 4.00 |
| 5.00 | Administrative and General | 0 | o | 0 | | 0 -205,844 | 1,158,237 | 5.00 |
| | HHA REIMBURSABLE SERVICES | | | | | | | 3.00 |
| 6.00 | Skilled Nursing Care | 0 | 0 | 0 | | 0 0 | 641,316 | 6.00 |
| 7.00 | Physical Therapy | 0 | 0 | 0 | | 0 0 | 204,391 | |
| 8.00 | Occupational Therapy | 0 | 0 | 0 | | 0 | 35,604 | |
| 9.00 | Speech Pathology | 0 | 0 | 0 | | 0 | 10,377 | 9.00 |
| 10.00 | Medical Social Services | 0 | 0 | 0 | | 0 | 466 | 10.00 |
| 11.00 12.00 | Home Health Aide | 0 | 0 | 0 | | 0 | 211,423 | 11.00 |
| 13.00 | Supplies (see instructions) Drugs | 0 | 0 | 0 | 1 | 0 | 0 | 12.00 |
| 14.00 | Drugs | 0 | , | 0 | | 0 | 0 | 13.00 |
| 14.00 | HHA NONREIMBURSABLE SERVICES | 0 | 0 | 0 | | 0 0 | 0 | 14.00 |
| 15.00 | Home Dialysis Aide Services | 0 | 0 | | r | 0 | | |
| 16.00 | Respiratory Therapy | 0 | 0 | 0 | l. | 0 0 | 0 | |
| 17.00 | | ŏ | 0 | 0 | | 0 | 0 | |
| 18.00 | Clinic | ŏ | ٥ | 0 | | 0 | 0 | , |
| 19.00 | Health Promotion Activities | o o | ŏ | 0 | | 0 | 0 | |
| 20.00 | Day Care Program | 0 | Ö | o 0 | | 0 | .0 | 20.00 |
| 21.00 | | o | 0 | ő | | 0 0 | 0 | 21.00 |
| 22.00 | | 0 | 0 | 0 | | o o | 54,234 | |
| 23.00 | | 0 | o | 0 | | ol ol | • | 23.00 |
| | Total (sum of lines 1-23) | 0 | j ol | 0 | | 0 -205,844 | 1,158,237 | |
| 25.00 | Cost To Be Allocated (per Worksheet H-1, Part I) | 0 | 0 | 0 | | 0 | 205,844 | |
| 26.00 | Unit Cost Multiplier | 0.000000 | 0.000000 | 0.000000 | 0.00000 | ool | 0.177722 | 26.00 |

HHA CCN:

157061

12/31/2012

Home Health

Date/Time Prepared: 5/29/2013 8:08 am

Agency I CAPITAL RELATED COSTS Cost Center Description HHA Trial NEW BLDG & NEW MVBLE **EMPLOYEE Subtotal** OTHER Balance (1) FIXT **EOUTP** BENEFITS **ADMINISTRATIVE** AND GENERAL 0 1.00 2.00 4.00 4A 5.01 Administrative and General 1.00 5,318 30,207 35,525 4,576 1.00 Skilled Nursing Care 2.00 755,290 0 0 755,290 0 97,286 2.00 0 3.00 Physical Therapy 240,716 0 0 240,716 31,006 3.00 4.00 Occupational Therapy 41,932 5,401 41,932 4.00 Speech Pathology 5.00 12,221 0 0 12,221 1,574 5.00 6.00 Medical Social Services 549 0 0 549 71 6.00 7.00 Home Health Aide 248,998 248,998 32,072 7.00 8.00 Supplies (see instructions) 0 0 0 0 8.00 9.00 Drugs 0 0 0 9.00 10.00 DME 0 0 10.00 Home Dialysis Aide Services 11.00 0 0 11,00 12.00 Respiratory Therapy 0 0 12.00 13.00 Private Duty Nursing 0 0 13.00 14.00 Clinic 0 0 14.00 15.00 Health Promotion Activities 0 0 15.00 16.00 Day Care Program 0 0 16.00 17.00 Home Delivered Meals Program n 0 0 0 17.00 18.00 Homemaker Service 63,873 63,873 8,227 18.00 19.00 All Others (specify) 502 502 65 19.00 20.00 Total (sum of lines 1-19) (2) 1,364,081 5,318 180,278 30,207 1,399,606 20.00 21.00 Unit Cost Multiplier: column 0.000000 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places. Cost Center Description BUSINESS MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPING DIETARY OFFICE REPAIRS **PLANT** LINEN SERVICE 5.02 6.00 7.00 8.00 9.00 10.00 1.00 Administrative and General 1,792 16,929 19,608 20,045 226 1.00 Skilled Nursing Care 2.00 37,862 0 0 0 2.00 0 3.00 Physical Therapy 12,067 0 0 0 0 0 3.00 Occupational Therapy 4.00 0 2,102 0 0 0 0 4.00 5.00 Speech Pathology 613 0 0 0 0 5.00 6.00 Medical Social Services 28 0 6.00 7.00 Home Health Aide 12,482 0 0 0 0 7.00 8.00 Supplies (see instructions) 0 0 0 8.00 9.00 Drugs 0 9.00 10.00 0 10.00 11.00 Home Dialysis Aide Services 0 11.00 12.00 Respiratory Therapy O 0 12.00 13.00 Private Duty Nursing 0 0 0 13.00 14.00 Clinic 0 14.00 15.00 Health Promotion Activities 0 15.00 16.00 Day Care Program 0 0 0 16.00 17.00 Home Delivered Meals Program 0 0 17.00 18.00 Homemaker Service 3,202 0 0 0 0 18.00 19.00 All Others (specify) 25 0 0 19.00 20.00 Total (sum of lines 1-19) (2) 70,173 16,929 19,608 20,045 226 20.00 Unit Cost Multiplier: column 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to

6 decimal places.

line 20 must agree with Wkst. A, column 7, line 101.

⁽²⁾ Columns 0 through 26, line 20 must agree with the corresponding columns of wkst. B, Part I, line 101.

Health Financial Systems WABASH COUNTY HOSPITAL In Lieu of Form CMS-2552-10 ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS 151310 | Period: | Worksheet H-2 | Part I |
157061 | To | 12/31/2012 | Date/Time Prepared: | Date/Time Prepared: | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | Provider CCN: 151310 HHA CCN:

| | | | | | | Home Health | PPS | |
|---------------|--|----------------------|---------------------------|---------------------------|-----------|------------------------------------|-----------|----------------|
| | Cost Center Description | CAFETERIA | NURSING ADMINISTRATION | CENTRAL SERVICES & SUPPLY | PHARMACY | Agency I MEDICAL RECORDS & LIBRARY | Subtotal | |
| | | 11.00 | 13.00 | 14.00 | 15.00 | 16.00 | 24.00 | |
| 1.00 | Administrative and General | C | 0 | 0 | | 0 | 98,701 | 1.00 |
| 2.00 | Skilled Nursing Care | C | • | _ |) (| 0 | 890,438 | 2.00 |
| 3.00 | Physical Therapy | C | 0 | | 0 | 0 | 283,789 | |
| 4.00 | Occupational Therapy | C | 0 | _ | 1 | 0 | 49,435 | 4.00 |
| 5.00 6.00 | Speech Pathology Medical Social Services | 0 | 0 | , | 1 | 1 | 14,408 | |
| 7.00 | Home Health Aide | | , | _ | 1 | 1 | 648 | |
| 8.00 | Supplies (see instructions) | | 0 | - | 1 | 1 | 293,552 | 1 |
| 9.00 | Drugs | | 1 | _ | 1 | · · | 0 | |
| 10.00 | DME | | _ | 1 | _ | -1 | 0 | |
| 11.00 | Home Dialysis Aide Services | | _ | 1 | 1 | | 0 | 10.00 |
| 12.00 | Respiratory Therapy | i o | | 1 | - | | 0 | 11.00 12.00 |
| 13.00 | Private Duty Nursing | i o | _ | _ | 1 | 1 | 0 | 13.00 |
| 14.00 | Clinic | 0 | | _ | 1 | 1 7 | 0 | |
| 15.00 | Health Promotion Activities | 0 | 0 | | | 1 "1 | 0 | 15.00 |
| 16.00 | Day Care Program | 0 | 0 | 0 | | 1 | o | 16.00 |
| 17.00 | Home Delivered Meals Program | 0 | 0 | 0 | ol c | 0 | 0 | 17.00 |
| | Homemaker Service | 0 | 0 | - | ď | 0 | 75,302 | |
| 19.00 | All Others (specify) | 0 | 0 | 0 | e C | 0 | 592 | 19.00 |
| | Total (sum of lines 1-19) (2) | 0 | 0 | . 0 |) O | 0 | 1,706,865 | 20.00 |
| 21.00 | Unit Cost Multiplier: column 26, line 1 divided by the sum | | | | | | | 21.00 |
| | of column 26, line 20 minus | | | | | | | |
| | column 26, line 1, rounded to | | | | | | | |
| | 6 decimal places. | | | | | | | |
| | Cost Center Description | Intern & | Subtota1 | Allocated HHA | Total HHA | | | |
| | | Residents Cost | | A&G (see Part | Costs | | | |
| | | & Post | | 11) | | | | |
| | | Stepdown | | | | | | |
| | | Adjustments 25.00 | 26.00 | 27.00 | 39.00 | - | | |
| 1.00 | Administrative and General | 23.00 | 98,701 | 27.00 | 28.00 | | | 4 00 |
| 2.00 | Skilled Nursing Care | o o | 890,438 | 54,650 | 945,088 | | | 1.00 |
| 3.00 | Physical Therapy | o | 283,789 | 17,418 | , | | | 2.00 |
| 4.00 | Occupational Therapy | 0 | 49,435 | 3,034 | | | | 3.00 4.00 |
| 5.00 | Speech Pathology | 0 | 14,408 | | | | | 5.00 |
| 6.00 | Medical Social Services | 0 | 648 | 40 | | | | 6.00 |
| 7.00 | Home Health Aide | 0 | 293,552 | 18,017 | 311,569 | | | 7.00 |
| 8.00 | Supplies (see instructions) | 0 | 0 | 0 | 0 | | | 8.00 |
| 9.00 10.00 | Drugs DME | 0 | 0 | 0 | 0 | | | 9.00 |
| 11.00 | Home Dialysis Aide Services | 0 | 0 | 0 | 0 | | | 10.00 |
| 12.00 | Respiratory Therapy | 0 | 0 | 0 | 0 | | | 11.00 |
| 13.00 | Private Duty Nursing | 0 | 0 | 0 | 0 | | | 12.00 |
| 14.00 | Clinic | 0 | U | 0 | 0 | | | 13.00 |
| | Health Promotion Activities | 0 | 0 | U | 0 | | | 14.00 |
| 16.00 | Day Care Program | l ol | 0 | 0 | 0 | | | 15.00 |
| 17.00 | Home Delivered Meals Program | 0 | 0 | 0 | _ | | | 16.00 |
| 18.00 | Homemaker Service | Ö | 75,302 | 4,622 | | | | 17.00 |
| 19.00 | All Others (specify) | o | 592 | 36 | | | | 18.00 19.00 |
| 20.00 | Total (sum of lines 1-19) (2) | o | 1,706,865 | 98,701 | | | | 20.00 |
| 21.00 | Unit Cost Multiplier: column | | | 0.061375 | | | | 21.00 |
| | 26, line 1 divided by the sum | | | | | | | -1.00 |
| | of column 26, line 20 minus column 26, line 1, rounded to | | | | | | İ | |
| | 6 decimal places. | | | | | | | |
| | praces, | | | i | | | | |

⁽¹⁾ Column 0, line 20 must agree with wkst. A, column 7, line 101.(2) Columns 0 through 26, line 20 must agree with the corresponding columns of wkst. B, Part I, line 101.

| | | | | | | Home Health | PPS | |
|--------------|---|-------------------------------|---|---|----------------|---|-------------------------------------|----------------|
| | | CAPITAL REL | ATED COSTS | T | T | Agency I | | |
| | Cost Center Description | NEW BLDG & FIXT (SQUARE FEET) | NEW MVBLE EQUIP (DOLLAR VALUE) | EMPLOYEE BENEFITS (GROSS SALARIES) | Reconciliation | OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST) | BUSINESS OFFICE (ACCUM. COST) | |
| | | 1.00 | 2.00 | 4.00 | 5A.01 | 5.01 | 5.02 | |
| 1.00 2.00 | Administrative and General | 1,910 | C | , | _ | 30,323 | 35,748 | |
| 3.00 | Skilled Nursing Care Physical Therapy | 0 | 0 | _ | 1 | | | |
| 4.00 | Occupational Therapy | 0 | | 1 | _ | , | | |
| 5.00 | Speech Pathology | 0 | 0 | | 1 | , | 41,932 | |
| 6.00 | Medical Social Services | 0 | 0 | 1 | 1 | , | 12,221 | |
| 7.00 | Home Health Aide | 0 | 0 | 1 | | 1 | 549 | |
| 8.00 | Supplies (see instructions) | ő | 0 | 1 | | 2,0,330 | , | |
| 9.00 | Drugs | ő | 0 | 1 | 1 | 1 | 0 | |
| 10.00 | DME | l ol | Ő | 1 | 1 | , J | 0 | |
| 11.00 | Home Dialysis Aide Services | 0 | . 0 | 1 | | 9 | 0 | 11.00 |
| 12.00 | Respiratory Therapy | 0 | 0 | Ō | 1 | | 0 | 12.00 |
| | Private Duty Nursing | 0 | 0 | 0 | ō | · · · · · · · · · · · · · · · · · · · | 0 | 13.00 |
| 14.00 | Clinic | 0 | 0 | 0 | 0 | 0 | 0 | 14.00 |
| 15.00 | Health Promotion Activities | 0 | 0 | 0 | 0 | 0 | 0 | 15.00 |
| | Day Care Program | 0 | 0 | , | 0 | 0 | 0 | 16.00 |
| | Home Delivered Meals Program Homemaker Service | 0 | 0 | 0 | 0 | 1 | 0 | 17.00 |
| | All Others (specify) | 0 | 0 | 0 | 0 | 05,0.3 | 63,873 | 18.00 |
| | Total (sum of lines 1-19) | 1 010 | 0 | 0 | 0 | 502 | | 19.00 |
| | Total cost to be allocated | 1,910 5,318 | 0 | 023,010 | | 1,399,606 | 1,399,829 | |
| | Unit_cost multiplier | 2.784293 | 0.000000 | 30,207 0.036675 | | 180,278 | 70,173 | |
| | Cost Center Description | MAINTENANCE & | OPERATION OF | LAUNDRY & | HOUSEKEEPING | 0.128806 DIETARY | 0.050130 CAFETERIA | 22.00 |
| | · | REPAIRS | PLANT | LINEN SERVICE | (SQUARE | (MEALS | (HOURS) | |
| | | (SQUARE | (SQUARE | (POUNDS OF | FEET) | SERVED) | (1100KS) | |
| | | FEET) | FEET) | LAUNDRY) | | | | |
| 1.00 | Administrative and General | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | 11.00 | |
| 2.00 | Skilled Nursing Care | 1,910 | 1,910 0 | | 1,910 | 15 | 0 | 1.00 |
| 3.00 | Physical Therapy | | 0 | | 0 | 0 | 0 | 2.00 |
| 4.00 | Occupational Therapy | 0 | 0 | | 0 | 0 | 0 | 3.00 |
| 5.00 | Speech Pathology | ŏ | 0 | | 0 | 0 | 0 | 4.00 |
| 6.00 | Medical Social Services | 0 | ŏ | o o | 0 | 0 | 0 | 5.00 |
| 7.00 | Home Health Aide | 0 | 0 | 0 | ő | 0 | ol | 6.00 7.00 |
| 8.00 | Supplies (see instructions) | 0 | 0 | 0 | 0 | ő | 0 | 8.00 |
| 9.00 | Drugs | 0 | 0 | 0 | 0 | o | 0 | 9.00 |
| 10.00 | DME | 0 | 0 | 0 | 0 | 0 | ő | 10.00 |
| | Home Dialysis Aide Services | 0 | 0 | 0 | 0 | 0 | o | 11.00 |
| | Respiratory Therapy Private Duty Nursing | 0 | 0 | 0 | 0 | 0 | 0 | 12.00 |
| | Clinic | 0 | 0 | 0 | 0 | 0 | 0 | 13.00 |
| | Health Promotion Activities | 0 | 0 | 0 | 0 | 0 | 0 | 14.00 |
| | Day Care Program | 0 | 0 | 0 | 0 | 0 | 0 | 15.00 |
| 17.00 | Home Delivered Meals Program | 0 | O O | 0 | 0 | 0 | 0 | 16.00 |
| 18.00 | Homemaker Service | 0 | 0 | 0 | 0 | 0 | 0 | 17.00 |
| 19.00 | All Others (specify) | o | o | 0 | 0 | 0 | 0 | 18.00 |
| 20.00 | Total (sum of lines 1-19) | 1,910 | 1,910 | 0 | 1,910 | 15 | 0 | 19.00 |
| 21.00 | Total cost to be allocated | 16,929 | 19,608 | ő | 20,045 | 226 | 0 | 20.00 21.00 |
| 22.00 | Unit cost multiplier | 8.863351 | 10.265969 | 0.000000 | 10.494764 | 15.066667 | 0.000000 | |
| | | · | , | -1 | | | 0.000000 | 22.00 |

| ALLOCAT BASIS | TION OF GENERAL SERVICE COSTS | TO HHA COST CEN | TERS STATISTICA | Provider | CCN: 151310 | Period: From 01/01/2012 | Worksheet H- Part II | 2 |
|---|---|-----------------|-----------------|----------|-------------|----------------------------|-------------------------|------|
| | | | | HHA CCN: | 157061 | To 12/31/2012 | | |
| | | | | | | Home Health | PPS | |
| *************************************** | Cost Center Description | NURSING | CENTRAL | PHARMACY | MEDICAL | Agency I | L | т |
| | | ADMINISTRATION | SERVICES & | (COSTED | RECORDS & | | | |
| | | | SUPPLY | REQUIS.) | LIBRARY | | | |
| | | (DIRECT | (COSTED | | (GROSS REV) |) | | |
| | | NRSING HRS) | REQUIS.) | | | | | |
| | | 13.00 | 14.00 | 15.00 | 16.00 | | | 7 |
| | Administrative and General | 0 | 0 | 0 | | 0 | | 1.0 |
| | Skilled Nursing Care | 0 | 0 | 0 | | 0 | | 2.0 |
| | Physical Therapy | 0 | O | 0 | | 0 | | 3.0 |
| | Occupational Therapy | 0 | 0 | 0 | | 0 | | 4.0 |
| | Speech Pathology | 0 | 0 | 0 | | 0 | | 5.0 |
| | Medical Social Services Home Health Aide | 0 | 0 | 0 | | 0 | | 6.0 |
| 1 | | 0 | 0 | 0 | | 0 | | 7.0 |
| | Supplies (see instructions) Drugs | 0 | 0 | 0 | | 0 | | 8.0 |
| | Drugs DME | 0 | 0 | 0 | | 0 | | 9.0 |
| | Home Dialysis Aide Services | 0 | 0 | 0 | | 0 | | 10.0 |
| | Respiratory Therapy | | 0 | 0 | | 0 | | 11.0 |
| | Private Duty Nursing | 0 | 0 | U | | 0 | | 12.0 |
| | Clinic | 0 | 0 | 0 | | 0 | | 13.0 |
| | Health Promotion Activities | 0 | 0 | 0 | | 0 | | 14.0 |
| | Day Care Program | 0 | 0 | o | | 0 | | 15.0 |
| | Home Delivered Meals Program | o o | 0 | 0 | | 0 | | 16.0 |
| 8.00 | Homemaker Service | o | 0 | 0 | | 0 | | 17.0 |
| 9.00 | All Others (specify) | o | ő | 0 | | 0 | | 19.0 |
| 0.00 | Total (sum of lines 1-19) | O | ő | o | | ő | | 20.0 |
| | Total cost to be allocated | 0 | 0 | ŏ | | ŏ | | 20.0 |
| 22.00 l | Jnit cost multiplier | 0.000000 | 0.000000 | 0.000000 | 0.0000 | nol | | 22.0 |

| APPOR | RTIONMENT OF PATIENT SERVICE COS | TS | WABASH COUN | | | de 1 | IN L1 | eu of Form CMS- | |
|------------|--|-----------------|---|--|------|-----------------------------|---|--|----------------|
| | TENTE COS | 15 | | Provi | | CCN: 151310 157061 | Period: From 01/01/201 To 12/31/201 | | _ |
| | | | | | | | | 5/29/2013 8: | epare 08 am |
| | Coat Contain | | | | Titl | e XVIII | Home Health Agency I | PPS | oo uiii |
| | Cost Center Description | From, Wkst. | Facility Cost | | | Total HHA | Total Visits | Average Cost | T |
| | | H-2, Part I, | • | Ancillar | | Costs (cols. | 1 | Per Visit | |
| | | col. 28, line | H-2, Part I) | Costs (fr | | + 2) | | (col. $3 \div col.$ | |
| | | 0 | 1.00 | Part II |) | | | 4) | |
| | PART I - COMPUTATION OF LESSER | OF AGGREGATE | DECEMBER COST | 2.00 | | 3.00 | 4.00 | 5.00 | |
| | | or modificant E | FROGRAM COST, | AGGREGATE U | r in | E PROGRAM LIM | ITATION COST, C |)R | 1 |
| | Cost Per Visit Computation | | | And the second s | | | | | - |
| 1.00 | Skilled Nursing Care | 2.00 | 945,088 | 8 | | 945,08 | 8 3,80 | 1 340 4 | |
| 2.00 | Physical Therapy | 3.00 | | 1 | 0 | | -, | | |
| 3.00 | Occupational Therapy | 4.00 | | | ő | , | _, _, _, | | |
| 4.00 | Speech Pathology | 5.00 | 15,292 | 2 | 0 | 15,29 | | , | |
| 5.00 | Medical Social Services | 6.00 | 688 | 3 | - | 68 | | | |
| 6.00 | Home Health Aide | 7.00 | 311,569 | 9 | | 311,56 | | , , , , , , | |
| 7.00 | Total (sum of lines 1-6) | | 1,626,313 | 3 | 0 | | | | 1 |
| | | | | | | Program Visit | | | 7.0 |
| | | | | | - 1 | | rt B | | 1 |
| | Cost Center Description | Cost Limits | CBSA No. (1) | Part A | | Not Subject t | | | |
| | | | | | | Deductibles & | | | |
| | | | | | | Coinsurance | | | |
| | Limitation Cost Computation | 0 | 1.00 | 2.00 | | 3.00 | 4.00 | 5.00 | |
| 8.00 | Skilled Nursing Care | | 115000 | | | | | The state of the s | |
| 9.00 | Physical Therapy | | 15999 | | 481 | 47 | | | 8.0 |
| 10.00 | | | 15999 | | 581 | 53 | | i | 9.0 |
| 11.00 | | | 15999 | | 129 | 8: | | | 10.0 |
| | Medical Social Services | | 15999 15999 | | 8 | 1 | 4 | | 11.00 |
| 13.00 | Home Health Aide | | 15999 | | 3 | | 4 | | 12.00 |
| 14.00 | Total (sum of lines 8-13) | | 17333 | | 130 | 487 | l . | | 13.00 |
| | | From Wkst H-2 | Facility Costs | Shared | 332 | 1,59 | | | 14.00 |
| | | Part I, col. | (from Wkst. | Ancillary | | Total HHA Costs (cols. : | Total Charges | Ratio (col. 3 | |
| | | 28, line | H-2, Part I) | Costs (fr | | + 2) | | ÷ col. 4) | |
| | | | , | Part II) | | + 2) | Record) | | |
| | | 0 | 1.00 | 2.00 | | 3.00 | 4.00 | 5.00 | |
| 5 00 | Supplies and Drugs Cost Computa Cost of Medical Supplies | | | | | | ,,,,,, | 3.00 | |
| 6.00 | Cost of Drugs | 8.00 | _ | 1 | 0 | (| 0 | 0.000000 | 15 00 |
| 0.00 | cost of brugs | 9.00 | 0 | | 0 | (| - | 0.000000 | |
| | | | Program Visits | | | Cost of | | 0.000000 | 10.00 |
| | | ſ | | | | Services | | | |
| | Cost Center Description | Don't A | Par | t B | | | Part B | | |
| | and content beach the ton | Part A | Not Subject to | Subject t | 0 | Part A | Not Subject to | Subject to | |
| | | | Deductibles & | | | | Deductibles & | Deductibles & | |
| | | 6.00 | Coinsurance 7.00 | Coinsuranc | | | Coinsurance | Coinsurance | |
| | PART I - COMPUTATION OF LESSER (BENEFICIARY COST LIMITATION | OF AGGREGATE P | ROGRAM COST A | 8.00 | | 9.00 | 10.00 | 11.00 | |
| | BENEFICIARY COST LIMITATION | | MOGIONI COST, A | GGREGATE UF | IHE | PROGRAM LIMI | TATION COST, OR | | |
| 0.0 | Cost Per Visit Computation | | , | | | | | | |
| .00 | Skilled Nursing Care | 481 | 474 | | | 119,504 | 117 765 | | |
| .00 | Physical Therapy | 581 | 535 | | | 79,260 | | | 1.00 |
| .00 | Occupational Therapy | 129 | 89 | | | 14,249 | | | 2.00 |
| .00 | Speech Pathology | 8 | 14 | | | 1,288 | -, | | 3.00 |
| .00 .00 | Medical Social Services | 3 | 4 | | | 129 | | ĺ | 4.00 |
| | Home Health Aide | 130 | 482 | | ľ | 5,438 | | | 5.00 |
| .00 | Total (sum of lines 1-6) | 1,332 | 1,598 | | İ | 219,868 | | | 6.00 |
| | Cost Center Description | | | | 1 | | 223,103 | | 7.00 |
| | Limitation Cost Computation | 6.00 | 7.00 | 8.00 | | 9.00 | 10.00 | 11.00 | |
| 00 | Skilled Nursing Care | | | | - | | | | |
| 00 | Physical Therapy | | | | | | | | 8 00 |
| | Occupational Therapy | | | | | | | | 8.00 |
| 1.00 | Speech Pathology | | | | | | | | 9.00 |
| .00 | Medical Social Services | | | | | | | | 10.00 |
| | Home Health Aide | | | | | | | | 11.00 12.00 |
| | HEATON AIGE | | | | - 1 | | | | 14.00 |
| | Total (sum of lines 8-13) | | | | ı | | | 1 | 13.00 |

| APPORTIONMENT OF PATIENT SERVICE COS | STS | WABASH COUNT | | CCN: 151310 | In L16 | u of Form CMS- | |
|--|--|------------------|--|---------------------|---------------------------------------|----------------|--|
| | | | Provider | CCN: 121310 | Period: From 01/01/2012 | Worksheet н-3 | ; |
| | | | HHA CCN: | 157061 | To 12/31/2012 | | pared |
| | | | Titl | e XVIII | Home Health | PPS | o aiii |
| | Droce | man Carran I al | | | Agency I | | |
| | Filog | gram Covered Cha | arges | Cost of Services | | | |
| . | | | 't B | | Part B | | |
| Cost Center Description | Part A | Not Subject to | Subject to | Part A | Not Subject to | Subject to | |
| | Deducti | | Deductibles & Deductibles & | | Deductibles & | Deductibles & | |
| | 6.00 | Coinsurance | Coinsurance | | Coinsurance | Coinsurance | |
| Supplies and Drugs Cost Comput | ations | 7.00 | 8.00 | 9.00 | 10.00 | 11.00 | |
| 5.00 Cost of Medical Supplies | .ac ions | | | | | | |
| 6.00 Cost of Drugs | | 2,080 | | | | | 15.0 |
| Cost Center Description | Total Program | 2,080 | 0 | | 0 | 0 | 16.0 |
| • | Cost (sum of | İ | | | | | |
| | cols. 9-10) | | | | | | |
| | 12 00 | | | | ļ | | |
| PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION | OF AGGREGATE F | PROGRAM COST, A | GGREGATE OF TH | E PROGRAM LIN | ITATION COST, OR | | |
| Cost Per Visit Computation | | | | | | | |
| .00 Skilled Nursing Care | 237,269 | | man and the control of the control o | | | | |
| | | | | | | | |
| | 152,245 | | | | | | |
| .00 Occupational Therapy | | | | | | | 2.0 |
| 00 Occupational Therapy 00 Speech Pathology | 152,245 | | | | | | 2.0 3.0 |
| 00 Occupational Therapy 00 Speech Pathology 00 Medical Social Services | 152,245 24,080 | | | | | | 2.0 3.0 4.0 |
| 00 Occupational Therapy 00 Speech Pathology 00 Medical Social Services 00 Home Health Aide | 152,245 24,080 3,542 301 25,600 | | | | | | 2.0 3.0 4.0 5.0 |
| .00 Occupational Therapy .00 Speech Pathology .00 Medical Social Services .00 Home Health Aide .00 Total (sum of lines 1-6) | 152,245 24,080 3,542 301 | | | | | | 1.0 2.0 3.0 4.0 5.0 6.0 |
| .00 Occupational Therapy .00 Speech Pathology .00 Medical Social Services .00 Home Health Aide | 152,245 24,080 3,542 301 25,600 443,037 | | | | · · · · · · · · · · · · · · · · · · · | · | 2.0 3.0 4.0 5.0 |
| 00 Occupational Therapy 00 Speech Pathology 00 Medical Social Services 00 Home Health Aide 00 Total (sum of lines 1-6) Cost Center Description | 152,245 24,080 3,542 301 25,600 | | | | - | | 2.0 3.0 4.0 5.0 6.0 |
| 00 Occupational Therapy 00 Speech Pathology 00 Medical Social Services 00 Home Health Aide 00 Total (sum of lines 1-6) Cost Center Description | 152,245 24,080 3,542 301 25,600 443,037 | | | | | | 2.0 3.0 4.0 5.0 6.0 |
| 00 Occupational Therapy 00 Speech Pathology 00 Medical Social Services 00 Home Health Aide 00 Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation 00 Skilled Nursing Care | 152,245 24,080 3,542 301 25,600 443,037 | | | | | · | 2.0 3.0 4.0 5.0 6.0 7.0 |
| 00 Occupational Therapy 00 Speech Pathology 00 Medical Social Services 00 Home Health Aide 00 Total (sum of lines 1-6) Cost Center Description 00 Skilled Nursing Care 00 Physical Therapy | 152,245 24,080 3,542 301 25,600 443,037 | | | | | · | 2.0 3.0 4.0 5.0 6.0 7.0 |
| Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy | 152,245 24,080 3,542 301 25,600 443,037 | | | | | | 2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0 |
| 00 Occupational Therapy 00 Speech Pathology 00 Medical Social Services 00 Home Health Aide 00 Total (sum of lines 1-6) Cost Center Description 00 Skilled Nursing Care 00 Physical Therapy 00 Occupational Therapy 00 Speech Pathology | 152,245 24,080 3,542 301 25,600 443,037 | | | | | | 2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0 10.0 |
| Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services | 152,245 24,080 3,542 301 25,600 443,037 | | | | | | 2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0 10.0 11.0 |
| .00 Occupational Therapy .00 Speech Pathology .00 Medical Social Services .00 Home Health Aide .00 Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation .00 Skilled Nursing Care Physical Therapy | 152,245 24,080 3,542 301 25,600 443,037 | | | | | | 2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0 10.0 |

| Health | Financial Systems | | WABASH COUNT | ү но | SPITAL | | | In Lie | u of Form CMS- | 2552-10 |
|--------------|--|----------------|-----------------|----------|--|-----------------------|-----|---------------------------------------|----------------|--------------|
| APPORT | TIONMENT OF PATIENT SERVICE COST | rs | | | Provider | CCN: 151310 157061 | Fro | riod: om 01/01/2012 12/31/2012 | | pared: |
| | | | | | Titl | e XVIII | ŀ | Home Health Agency I | PPS | |
| | Cost Center Description From Wkst. C, Cost to Charg Part I, col. Ratio 9, line | | | Cha p | Total HHA Charge (from Anc provider Costs records) x c | | | Transfer to Part I as Indicated | | |
| | | 0 | 1.00 | | 2.00 | 3.00 | | 4.00 | | |
| | PART II - APPORTIONMENT OF COS | T OF HHA SERVI | CES FURNISHED B | Y SH | ARED HOSPI | TAL DEPARTMEN | VTS | | | |
| 1.00 | Physical Therapy | 66.00 | 0.647872 | | | 0 | | ol. 2, line 2 | .00 | 1.00 |
| 2.00 3.00 | Occupational Therapy Speech Pathology | | | | | | | | | 2.00 |
| 4.00 | Cost of Medical Supplies | 71.00 | 0.486559 | | 0 | , | 0 0 | ol. 2, line 1 | 5 00 | 3.00 4.00 |
| 5.00 | Cost of Drugs | 73.00 | | | 0 | | | ol. 2, line 1 | | 5.00 |

| | | Provider CCN: 151310 Period: Worksheet H-From 01/01/2012 Part I-II | 4 |
|---|--|--|--|
| | | HHA CCN: 157061 To 12/31/2012 Date/Time Pr 5/29/2013 8: | |
| ~ | | Title XVIII Home Health PPS Agency I | OB AIII |
| | | Part B Part A Not Subject to Subject to | |
| | | Deductibles & Deductibles & Coinsurance Coinsurance | k |
| 1 | PART I - COMPUTATION OF THE LESSER OF | 1.00 2.00 3.00 REASONABLE COST OR CUSTOMARY CHARGES | |
| [1 | Reasonable Cost of Part A & Part B Se Reasonable cost of services | rvices | |
| | (see instructions) | 0 0 | 0 1.0 |
| | Total charges | 0 0 | 0 2.0 |
| | Customary Charges Amount actually collected from | 0 0 | 0 3.0 |
| | patients liable for payment for services on a charge basis | | 3.0 |
| | (from your records) Amount that would have been | | 0 4.0 |
| | realized from patients liable | | 4.0 |
| | for payment for services on a charge basis had such payment | | |
| - | been made in accordance with | | |
| | 42 CFR 413.13(b) Ratio of line 3 to line 4 (not | 0.000000 | |
| | to exceed 1.000000) | 0.000000 0.000000 0.00000 | 5.0 |
| | Total customary charges (see instructions) | 0 0 | 0 6.0 |
| 00 | Excess of total customary | 0 0 | 0 7.0 |
| 4 | charges over total reasonable cost (complete only if line 6 exceeds line 1) | | |
| 00 | Excess of reasonable cost over | 0 0 | 0 8.0 |
| | customary charges (complete only if line 1 exceeds line 6) | | |
| | Primary payer amounts | 0 | 0 9.0 |
| | | Part A Part B | 9.0 |
| | | Services Services 1.00 2.00 | |
| | | | |
| F | PART II - COMPUTATION OF HHA REIMBURS | EMENT SETTLEMENT | + |
| .00 | Total reasonable cost (see instructions) | EMENT SETTLEMENT 0 | 0 10.0 |
| .00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers | EMENT SETTLEMENT 0 216,484 235,46 | 5 11.0 |
| .00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers | EMENT SETTLEMENT 0 216,484 235,46 | 5 11.0 |
| .00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA | EMENT SETTLEMENT 0 216,484 235,46 | 5 11.0 0 12.0 |
| .00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP | EMENT SETTLEMENT 0 216,484 235,46 0 2,189 4,50 | 5 11.0 0 12.0 1 13.0 |
| .00 - .00 - .00 - | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes | EMENT SETTLEMENT 0 216,484 235,46 0 2,189 4,50 5,288 38 | 5 11.0 0 12.0 1 13.0 8 14.0 |
| .00 - .00 - .00 - .00 - .00 - .00 - | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP | EMENT SETTLEMENT 0 216,484 235,46 0 2,189 4,50 5,288 38 | 5 11.0 0 12.0 1 13.0 8 14.0 |
| .00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes With Outliers | EMENT SETTLEMENT 0 216,484 235,46 0 2,189 4,50 5,288 38 | 5 11.0 0 12.0 1 13.0 8 14.0 0 15.0 |
| .00 - | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes Total PPS Outlier Reimbursement - PEP Episodes | EMENT SETTLEMENT 0 216,484 235,46 0 2,189 4,50 5,288 38 0 | 5 11.0 0 12.0 1 13.0 8 14.0 0 15.0 |
| .00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes With Outliers Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments | ### SETTLEMENT 0 | 5 11.0 0 12.0 1 13.0 8 14.0 0 15.0 0 16.0 0 17.0 |
| .00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes With Outliers Total PPS Outlier Reimbursement - Full Episodes With Outliers Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments Designed Payments Designed Payments | ### SETTLEMENT 0 | 5 11.0 0 12.0 1 13.0 8 14.0 0 15.0 0 16.0 0 17.0 0 18.0 0 19.0 |
| .00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments Daygen Payments Drosthetic and Orthotic | ### SETTLEMENT 0 | 5 11.0 0 12.0 1 13.0 8 14.0 0 15.0 0 16.0 0 17.0 0 18.0 0 19.0 |
| 00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes With Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DAME Payments DAME Payments Prosthetic and Orthotic Payments P | ### SETTLEMENT 0 | 5 11.0 0 12.0 1 13.0 8 14.0 0 15.0 0 16.0 0 17.0 0 18.0 0 19.0 0 20.0 |
| 00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments Description of the Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude Episonurance) Eubtotal (sum of lines 10 thru Elo minus line 21) | ### SETTLEMENT 0 | 5 11.0 0 12.0 1 13.0 8 14.0 0 15.0 0 16.0 0 17.0 0 18.0 0 19.0 0 20.0 |
| 00 00 00 00 00 00 00 00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DATE PAYMENTS DATE PAYMENTS PAYER B deductibles billed to Medicare patients (exclude Loinsurance) Eubtotal (sum of lines 10 thru EUD minus line 21) Excess reasonable cost (from | ### SETTLEMENT 0 | 5 11.0 0 12.0 1 13.0 8 14.0 0 15.0 0 16.0 0 17.0 0 18.0 0 19.0 0 20.0 0 21.0 0 22.0 0 22.0 |
| 00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Teleimbursement - Full Episodes Total PPS Outlier Teleimbursement - PEP Episodes Total PPS Outlier Teleimbursement - PEP Episodes Total Other Payments Total Other Payments Total Other Payments Total Other Payments Total Other Teleimbursement - PEP Episodes Total Other Payments Total Other Payments Total Other Payments Total Other Payments Total Other Teleimbursement - PEP Episodes Total Other Payments Total Payments Total PPS Outlier Total PPS Outlier Total PPS Outlier To | O 216,484 235,46 O | 5 11.0 0 12.0 1 13.0 8 14.0 0 15.0 0 16.0 0 17.0 0 18.0 0 19.0 0 20.0 0 21.0 0 23.0 0 23.0 |
| .00 .00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Teeimbursement - Full Episodes Total PPS Outlier Teeimbursement - PEP Episodes Total PPS Outlier Teeimbursement - PEP Episodes Total Other Payments Total PPS Reimbursement - Full Total PPS Reimbursement - Full Total PPS Reimbursement - LUPA Total PPS Reimbursement - LUPA Total PPS Reimbursement - LUPA Total PPS Reimbursement - PEP Total PPS Reimbur | ### SETTLEMENT 0 | 5 11.0 0 12.0 1 13.0 8 14.0 0 15.0 0 16.0 0 17.0 0 18.0 0 19.0 0 20.0 0 21.0 4 22.0 4 24.0 4 24.0 |
| .00 .00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Fotal PPS Reimbursement - PEP Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes With Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments Daygen Payments Daygen Payments Prosthetic and Orthotic Payments Payments Payments Dayments Prosthetic and Orthotic Dayments Payments Dayments Dayments Prosthetic and Orthotic Dayments Day | ### SETTLEMENT 0 | 5 11.0 0 12.0 1 13.0 8 14.0 0 15.0 0 16.0 0 17.0 0 18.0 0 19.0 0 20.0 0 21.0 0 23.0 0 23.0 0 25.0 0 25.0 |
| .00 .00 | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DAY Payments DAY Payments DAY Payments Part B deductibles billed to Medicare patients (exclude coinsurance) Subtotal (sum of lines 10 thrue to minus line 21) Excess reasonable cost (from ine 8) Subtotal (line 22 minus line 13) Total PPS Outlier Total PPS Outlier Total PPS Outlier Total PPS Outlier Total PPS Reimbursement - PEP Total PPS | ### SETTLEMENT 0 | 5 11.00 0 12.00 1 13.00 8 14.00 0 15.00 0 16.00 0 17.00 0 18.00 0 19.00 0 20.00 0 21.00 0 23.00 0 24.00 0 25.00 |

| <u>Health</u> | Financial Systems | WABASH CO | OUNTY HOSPITAL | | In Lie | u of Form CMS- | 2552-10 |
|---------------|---|--|----------------------|-----------------------|---|--------------------|---------|
| CALCUL | ATION OF HHA REIMBURSEMENT SETTLEME | NT | Provider HHA CCN: | CCN: 151310 157061 | Period: From 01/01/2012 To 12/31/2012 | | pared: |
| | | | ritl | le XVIII | Home Health Agency I | PPS | |
| | | | | | Part A Services | Part B Services | |
| 20.00 | | The second secon | | | 1.00 | 2.00 | |
| 29.00 | Total costs - current cost reporting period (line 26 plus line 27) | | | | 223,961 | 240,354 | 29.00 |
| 30.00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | | | o | 0 | 30.00 |
| 31.00 | Subtotal (line 29 plus/minus line 30) | | | | 223,961 | 240,354 | 31.00 |
| 32.00 | Interim payments (see instructions) | | | | 223,961 | 240,354 | 32.00 |
| 33.00 | Tentative settlement (for contractor use only) | | | | О | . 0 | 33.00 |
| 34.00 | Balance due provider/program (line 31 minus lines 32 and 33) | | | | 0 | 0 | 34.00 |
| 35.00 | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II. section 115.2 | | | | o | 0 | 35.00 |

| PROGR | SIS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED AM BENEFICIARIES | TO Provider HHA CCN: | CCN: 151310 157061 | Period: From 01/01/2012 To 12/31/2012 Home Health | u of Form CMS-2 Worksheet H-5 Date/Time Prep 5/29/2013 8:08 | pared |
|------------|--|--|-----------------------|--|--|--------------|
| | | Inpatien | t Part A | Agency I Part B | | |
| | | mm/dd/yyyy | Amazina | /11/ | | |
| - | | 1.00 | Amount 2.00 | mm/dd/yyyy 3.00 | Amount 4.00 | |
| 1.00 | Total interim payments paid to | - Andrewson - Andr | 223,96 | | 240,354 | 1.0 |
| 2.00 | provider Interim payments payable on | | • | | 275,35 | 1.0 |
| | individual bills, either submitted or to be submitted to the contractor for services | | | 0 | 0 | 2.00 |
| | rendered in the cost reporting period. If none, write "NONE" | | • | | | |
| 3.00 | or enter a zero List separately each | | | | | |
| | retroactive lump sum | | | | | 3.00 |
| | adjustment amount based on | | | | | |
| | subsequent revision of the interim rate for the cost | | | | | |
| | reporting period. Also show | | | | | |
| | date of each payment. If none. | | | | | |
| | write "NONE" or enter a zero. (1) | | | | | |
| | Program to Provider | | | | | |
| .01 | | | | ol - | 0 | 2 0 |
| .02 | | | | o i | Ö | 3.02 |
| .04 | | ĺ | | 0 | ō | 3.03 |
| .05 | | | | 0 | 0 | 3.04 |
| | Provider to Program | | | 0 | 0 | 3.05 |
| .50 | | | | 0 | 0 | 3.50 |
| .52 | | | | 0 | 0 | 3.51 |
| .53 | | | | | 0 | 3.52 |
| .54 .99 | Subtotal (sum of lines | | | o l | 0 | 3.53 3.54 |
| | 3.01-3.49 minus sum of lines 3.50-3.98) | | (| | o | 3.99 |
| .00 | Total interim payments (sum of lines 1, 2, and 3.99) | | 223,96 | L I | 240,354 | 4.00 |
| | (transfer to Wkst. H-4, Part | | | | | |
| | II, column as appropriate, | | | | | |
| | Tine 32) TO BE COMPLETED BY CONTRACTOR | | | | | |
| .00 | List separately each tentative | | | | | |
| [| settlement payment after desk | | | | | 5.00 |
| | review. Also show date of each payment. If none, write "NONE" | | | | | |
| | or enter a zero. (1) | | | | | |
| [| Program to Provider | | | | | |
| .01 | | | (| | 0 | 5.01 |
| .03 | | | C | | 0 | 5.02 |
| Ì | Provider to Program | | | | 0 | 5.03 |
| 50 | | | | | 0 | 5.50 |
| 52 | | | 0 | | 0 | 5.51 |
| 99 | Subtotal (sum of lines | | 0 | 1 | 0 | 5.52 |
| | 5.01-5.49 minus sum of lines | | 0 | 1 | O | 5.99 |
| | 5.50-5.98) Determined net settlement | | | | | |
| | amount (balance due) based on | | | | | 6.00 |
| 1 | the cost report. (1) | | | | | |
| 01 9 | SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM | | 0 | | o | 6.01 |
| | Total Medicare program | | 0 | | -1 | 6.02 |
| - | liability (see instructions) | | 223,961 | | | 7.00 |

| Health Financial Systems | | BASH COUNTY HO | SPITAL | | | In Lie | u of Form CMS- | -2552-10 |
|--|--|----------------|----------|------------|-------|----------|--|------------------|
| ANALYSIS OF PAYMENTS TO PROVIDER-BASED PROGRAM BENEFICIARIES | HHAS FOR SERVICES | RENDERED TO | | CN: 151310 | | /01/2012 | Worksheet H- | 5 |
| | | | HHA CCN: | 157061 | то 12 | /31/2012 | Date/Time Pro 5/29/2013 8:0 | epared: 08 am |
| | | | | | Home | Health | PPS | |
| | | | | | Ager | icy I | | |
| | | | | | Cont | ractor | Date | |
| | | A 16/2 | | | Nu | mber | (Mo/Day/Yr) | |
| | The second section of the second seco | | 0 | | 1 | .00 | 2.00 | |
| 8.00 Name of Contractor | | | | | | | The second secon | 8.00 |

| ANALYS | SIS OF PROVIDER-BASED HOSPICE COSTS | | Provider | CCN: 151310 | Period: | Worksheet K | |
|--------|---|--|---|--|---|--------------------------------|-------|
| | | | Hospice (| CCN: 151545 | From 01/01/2012 To 12/31/2012 | Date/Time Pre 5/29/2013 8:0 | |
| | | | | | Hospice I | | |
| | | Salaries (from Wkst. K-1) B | | Transportation (see inst.) | on Contracted Services (from Wkst. K-3) | Other | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | GENERAL SERVICE COST CENTERS | era se ^t a de escare com a com aporten ja a samo con porte propositivo. | | and the same of th | | | |
| 1.00 | Capital Related Costs-Bldg and Fixt. | | - 11 - 11 - 12 - 12 - 12 - 12 - 12 - 12 | | 0 | 0 | 1.00 |
| 2.00 | Capital Related Costs-Movable Equip. | | | | 0 | 0 | |
| 3.00 | Plant Operation and Maintenance | 0 | 0 | | 0 0 | 0 | 1 |
| 4.00 | Transportation - Staff | o | 0 | | 0 0 | 0 | 1 |
| 5.00 | Volunteer Service Coordination | o | 0 | | 0 0 | 0 | 1 |
| 6.00 | Administrative and General | 373,674 | 162,006 | 30,30 | 00 0 | 36,624 | 1 |
| | INPATIENT CARE SERVICE | | | <u> </u> | | | 1 |
| 7.00 | Inpatient - General Care | 0 | 0 | pr | 0 0 | 0 | 7.00 |
| 8.00 | Inpatient - Respite Care | o | 0 | | 0 0 | 0 | 1 |
| | VISITING SERVICES | | | | | | 1 |
| 9.00 | Physician Services | O | | | 0 0 | 30,000 | 9.00 |
| 10.00 | Nursing Care | 0 | 0 | , | 0 0 | 0 | 1 |
| 11.00 | Nursing Care-Continuous Home Care | 0 | 0 | | 0 0 | 0 | |
| | Physical Therapy | 0 | 0 | , | 0 0 | Ô | l . |
| 13.00 | Occupational Therapy | 0 | 0 | • | 0 0 | o o | |
| 14.00 | Speech/ Language Pathology | 0 | 0 | | o o | 0 | |
| | Medical Social Services | 0 | 0 | | 0 0 | 0 | |
| 16.00 | Spiritual Counseling | 0 | 0 | | 0 0 | o o | |
| 17.00 | Dietary Counseling | 0 | 0 | | o o | 0 | |
| 18.00 | Counseling - Other | 0 | 0 | | o o | 0 | |
| 19.00 | Home Health Aide and Homemaker | 0 | 0 | | o o | 0 | 1 |
| 20.00 | HH Aide & Homemaker - Cont. Home Care | 0 | 0 | | o o | 0 | |
| 21.00 | Other | . 0 | 0 | | o o | o. | 1 |
| | OTHER HOSPICE SERVICE COSTS | | | | | | |
| | Drugs, Biological and Infusion Therapy | 0 | 0 | | 0 0 | 89,357 | 22.00 |
| 23.00 | Analgesics | 0 | 0 | | 0 | 0 | |
| | Sedatives / Hypnotics | 0 | 0 | | 0 0 | 0 | |
| | Other - Specify | 0 | 0 | | 0 0 | 0 | |
| 26.00 | Durable Medical Equipment/Oxygen | 0 | . 0 | | 0 0 | 56,708 | |
| 27.00 | Patient Transportation | 0 | 0 | | 0 0 | 0 | |
| 28.00 | Imaging Services | 0 | 0 | | 0 0 | 0 | 28.00 |
| | Labs and Diagnostics | 0 | 0 | | 0 0 | 0 | 29.00 |
| | Medical Supplies | 0 | 0 | | 0 0 | 1,015 | |
| | Outpatient Services (including E/R Dept.) | o | 0 | | 0 0 | 0 | 31.00 |
| 32.00 | Radiation Therapy | 0 | 0 | | 0 0 | ő | 32.00 |
| 33.00 | Chemotherapy | 0 | 0 | | 0 0 | 0 | 33.00 |
| 34.00 | Other | 0 | 0 | | 0 0 | 0 | 34.00 |
| | HOSPICE NONREIMBURSABLE SERVICE | | | | | | 1 30 |
| | Bereavement Program Costs | 0 | 0 | | 0 0 | 0 | 35.00 |
| 36.00 | Volunteer Program Costs | O | 0 | | 0 0 | ŏ | |
| 37.00 | Fundraising | 0 | 0 | | ol o | ő | |
| 38.00 | Other Program Costs | | 0 | | ام ما | 0 | |

373,674

162,006

30,300

0

213,704 39.00

36.00 37.00 38.00

38.00 Other Program Costs 39.00 Total (sum of lines 1 thru 38)

| | Financial Systems SIS OF PROVIDER-BASED HOSPICE COSTS | WABASH COUNT | | CCN 151310 | In Li Period: | eu of Form CMS- | 2552- |
|----------|---|--------------|---------------|----------------|---------------------------------|-----------------|----------------|
| - NAL I. | SIS OF FROVIDER-BASED HOSPICE COSTS | | Provide | · CCN: 151310 | Period: From 01/01/201 | Worksheet K | |
| | | | Hospice | CCN: 151545 | | | |
| | | | | | Hospice I | | |
| | | | Reclassificat | i Subtotal (co | Adjustments | Total (col. 8 | |
| | | 1-5) | on_ | 6 ± col. 7 | | ± col. 9) | - Northeanness |
| | CTIPE AL CENTURE CONT. | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | 1 |
| .00 | GENERAL SERVICE COST CENTERS | | | | | | |
| .00 | Capital Related Costs-Bldg and Fixt. | 0 | 1 | 0 | -1 | 0 | |
| .00 | Capital Related Costs-Movable Equip. | 0 | | 0 | 0 | 0 | |
| .00 | Plant Operation and Maintenance | 0 | | 0 | 0 | 0 0 | , . |
| .00 | Transportation - Staff | 0 | | 0 | 0 | 0 | , ,, |
| .00 | Volunteer Service Coordination | 0 | | 0 | - 1 | 0 0 | 1 |
| .00 | Administrative and General | 602,604 | | 0 602,6 | 04 | 0 602,604 | 6. |
| 00 | INPATIENT CARE SERVICE | | | | | · | |
| .00 | Inpatient - General Care | 0 | | 0 | | 0 | 7. |
| .00 | Inpatient - Respite Care | 0 | | 0 | 0 | 00 | 8. |
| 00 | VISITING SERVICES | | p | | | | |
| .00 | Physician Services | 30,000 | | 0 30,0 | 00 | 0 30,000 | 9 |
| 00.0 | Nursing Care | 0 | | 0 | 0 | 0 0 | 10. |
| .00 | Nursing Care-Continuous Home Care | 0 | | 0 | 0 | 0 | 11. |
| .00 | Physical Therapy | 0 | | 0 | 0 | 0 | 12. |
| | Occupational Therapy | 0 | | 0 | 0 | 0 | 13. |
| .00 | Speech/ Language Pathology | 0 | | 0 | 0 | 0 | 14 |
| | Medical Social Services | 0 | | 0 | 0 | 0 | 15 |
| , 00 | Spiritual Counseling | 0 | | 0 | 0 | 0 | 16 |
| | Dietary Counseling | 0 | | 0 . | 0 | 0 | 17. |
| | Counseling - Other | 0 | | 0 | 0 | 0 | 18. |
| .00 | Home Health Aide and Homemaker | 0 | | 0 | 0 | 0 | 19. |
| .00 | HH Aide & Homemaker - Cont. Home Care | 0 | | 0 | 0 | 0 | 20 |
| .00 | Other | 0 | | 0 | 0 (| 0 | 21 |
| | OTHER HOSPICE SERVICE COSTS | | | | | | 1 |
| .00 | Drugs, Biological and Infusion Therapy | 89,357 | | 0 89,3 | 57 | 89,357 | 22 |
| .00 | Analgesics | 0 | | 0 | 0 | 0 | 23. |
| .00 | Sedatives / Hypnotics | 0 | | 0 | 0 | 0 | 24. |
| .00 | Other - Specify | 0 | | 0 | 0 | 0 | 25. |
| .00 | Durable Medical Equipment/Oxygen | 56,708 | | 0 56,7 | 08 | 56,708 | 26. |
| .00 | Patient Transportation | 0 | 1 | 0 | 0 | | 1 |
| .00 | Imaging Services | 0 | 1 | 0 | 0 | 0 | 28. |
| .00 | Labs and Diagnostics | 0 | | 0 | 0 (| 0 | 1 |
| .00 | Medical Supplies | 1,015 | , | 1,0 | 15 (| 1,015 | |
| .00 | Outpatient Services (including E/R Dept.) | 0 | | O | 0 | 0 | |
| .00 | Radiation Therapy | 0 | | 0 | 0 | 1 | 1 |
| .00 | Chemotherapy | 0 | (| 0 | 0 | 0 | |
| .00 | Other | 0 | | 0 | 0 | | 34. |
| 0.0 | HOSPICE NONREIMBURSABLE SERVICE | | | | | <u> </u> | - " |
| .00 | Bereavement Program Costs | 0 | | 0 | 0 (| 0 | 35. |
| | Volunteer Program Costs | 0 | | o | 0 | | 36. |
| .00 | Fundraising | 0 | (| o | 0 | o o | 37. |
| .00 | Other Program Costs | 0 | (| o | 0 | 1 | |
| 1.00 | Total (sum of lines 1 thru 38) | 779,684 | (| 779.6 | | _ | |

779,684

779,684

779,684 39.00

38.00 Other Program Costs
39.00 Total (sum of lines 1 thru 38)

| HOSPI | CE COMPENSATION ANALYSIS SALARIES AND WAGES | | | CCN: 151310 CCN: 151545 | Period: From 01/01/2 To 12/31/2 | 2012 2012 Da | rksheet K- te/Time Pr 29/2013 8: | epared: |
|-------|---|---------------------------------------|----------|--|---------------------------------------|---------------------|--|---------|
| | | | | | Hospice : | r + 3/ | 23/2013 0.1 | JO am |
| | | Administrator | Director | Social Services | Superviso | | Nurses | |
| | CENTRAL | 1.00 | 2.00 | 3.00 | 4.00 | - | 5.00 | |
| 1.00 | GENERAL SERVICE COST CENTERS | · · · · · · · · · · · · · · · · · · · | | Particular transfer to the second sec | | | | |
| 2.00 | Capital Related Costs-Bldg and Fixt. | | | 1 | | | | 1.00 |
| 3.00 | Capital Related Costs-Movable Equip. | | | | | | | 2.00 |
| 4.00 | Plant Operation and Maintenance | 0 | 0 | | 0 | 0 | (| 3.00 |
| 5.00 | Transportation - Staff | 0 | 0 | | 0 | 0 | C | 4.00 |
| | Volunteer Service Coordination | 0 | 0 | | 0 | 0 | 0 | 5.00 |
| 6.00 | Administrative and General | 0 | 0 | | 0 | 0 | C | 6.00 |
| 7 00 | INPATIENT CARE SERVICE | | | | | | | 1 |
| 7.00 | Inpatient - General Care | 0 | 0 | | 0 | 0 | | 7.00 |
| 8.00 | Inpatient - Respite Care | 0 | 0 | | 0 | o | Ċ | |
| | VISITING SERVICES | | | | | | and the Mark State of | 1 |
| 9.00 | Physician Services | 0 | 0 | | 0 | 0 | | 9.00 |
| 10.00 | | 0 | 0 | | 0 | o | Č | |
| 11.00 | Nursing Care-Continuous Home Care | 0 | 0 | | 0 | 0 | č | |
| 12.00 | | 0 | 0 | | 0 | 0 | Ö | 1 |
| | Occupational Therapy | 0 | 0 | , | 0 | o | | 1 |
| 14.00 | | 0 | 0 | | 0 | ŏ | Ö | |
| 15.00 | | 0 | 0 | | o | ŏ | Ö | |
| | Spiritual Counseling | o | 0 | | o | 0 | Ö | |
| 17.00 | - · · , · · · · · · · · · · | 0 | 0 | | Ô | ٥ | 0 | |
| 18.00 | | 0 | 0 | | Ö | 0 | 0 | |
| 19.00 | Home Health Aide and Homemaker | 0 | o O | | ŏ | ٥ | 0 | 1 |
| 20.00 | HH Aide & Homemaker - Cont. Home Care | 0 | ñ | | o l | 0 | - | |
| 21.00 | Other | o o | 0 | | 0 | 0 | 0 | |
| | OTHER HOSPICE SERVICE COSTS | J | | | 0 | U | 0 | 21.00 |
| 22.00 | Drugs, Biological and Infusion Therapy | | | | 7 | | | |
| 23.00 | Analgesics | | | | | | | 22.00 |
| 24.00 | Sedatives / Hypnotics | | - | | • | | | 23.00 |
| 25.00 | Other - Specify | | | | | | | 24.00 |
| 26.00 | Durable Medical Equipment/Oxygen | | | | | | | 25.00 |
| 27.00 | Patient Transportation | 0 | 0 | | | | _ | 26.00 |
| 28.00 | Imaging Services | 0 | 0 | | 0 | 0 | 0 | |
| 29.00 | Labs and Diagnostics | 0 | 0 | | 9 | 0 | 0 | |
| 30.00 | Medical Supplies | | 0 | | 0 | 0 | 0 | |
| 31.00 | Outpatient Services (including E/R Dept.) | 0 | U | | 0 | 0 | 0 | |
| 32.00 | Radiation Therapy | 0 | U O | | 0 | 0 | 0 | 1 -100 |
| 33.00 | Chemotherapy | 0 | 0 | | 0 | 0 | 0 | |
| 34.00 | Other | 0 | 0 | | 0 | 0 | 0 | |
| | HOSPICE NONREIMBURSABLE SERVICE | J | 0 | | 0 | 0 | 0 | 34.00 |
| 35.00 | Bereavement Program Costs | | | | -T | | |] |
| 36.00 | Volunteer Program Costs | 0 | 0 | | 0 | 0 | 0 | |
| 37.00 | Fundraising | 0 | 0 | | 0 | 0 | 0 | 36.00 |
| | Other Program Costs | 0 | 0 | | 0 | 0 | 0 | 37.00 |
| | Total (sum of lines 1 thru 38) | 0 | 0 | | 0 | 0 | 0 | 38.00 |
| | , | 0 | 0 | | 0 | 0 | 0 | 39.00 |

| HOSPI | CE COMPENSATION ANALYSIS SALARIES AND WAGES | | Provider | CCN: 151310 | Period: From 01/01/2012 | u of Form CMS-2552 Worksheet K-1 |
|-------|---|---------------------|-----------|-------------|----------------------------|--|
| | | | Hospice C | CN: 151545 | To 12/31/2012 | Date/Time Prepare 5/29/2013 8:08 am |
| | | | | | Hospice I | |
| | | Total Therapists | Aides | All-Other | Total (1) | |
| | | 6.00 | 7.00 | 8.00 | 9.00 | |
| | GENERAL SERVICE COST CENTERS | one and the second | | | | The second secon |
| 1.00 | Capital Related Costs-Bldg and Fixt. | | | | | 1. |
| 2.00 | Capital Related Costs-Movable Equip. | | | | | 2. |
| 3.00 | Plant Operation and Maintenance | | 0 | | 0 0 | 3. |
| 4.00 | Transportation - Staff | | 0 | | 0 0 | 4. |
| 5.00 | Volunteer Service Coordination | | 0 | | 0 | 5. |
| 5.00 | Administrative and General | | o | 373,6 | 74 373,674 | 1 |
| | INPATIENT CARE SERVICE | | | 3,310 | 373,074 | 6. |
| 7.00 | Inpatient - General Care | T | 0 | | 0 0 | |
| 3.00 | Inpatient - Respite Care | | o | | -1 | 7. |
| | VISITING SERVICES | | | | 0 0 | 8. |
| 9.00 | Physician Services | | 0 | | <u>a</u> | |
| 10.00 | Nursing Care | | 0 | | 0 0 | 9. |
| 11.00 | Nursing Care-Continuous Home Care | | -1 | | 0 | 10. |
| 12.00 | Physical Therapy | | 0 | | 0 | 11.0 |
| 3.00 | Occupational Therapy | | 0 | | 0 | 12. |
| 4.00 | Speech/ Language Pathology | 0 | 0 | | 0 | 13. |
| 5.00 | Medical Social Services | U | 0 | | 0 | 14. |
| 6 00 | Spiritual Counseling | | 0 | | 0 | 15. |
| 7 00 | Dietary Counseling | | 0 | | 0 | 16. |
| 8 00 | Counseling - Other | | 0 | | 0 | 17.0 |
| 9 00 | Home Health Aide and Homemaker | | 0 | | 0 | 18.0 |
| 00.00 | Hul Aide & Hammalana Homemaker | | 0 | | 0 | 19.0 |
| 1 00 | HH Aide & Homemaker - Cont. Home Care | | 0 | | 0 0 | 20.0 |
| 1.00 | Other | | 0 | | 0 | 21.0 |
| | OTHER HOSPICE SERVICE COSTS | | | | | |
| 2.00 | Drugs, Biological and Infusion Therapy | | | | | 22.0 |
| 3.00 | Analgesics | | | | | 23.0 |
| 4.00 | Sedatives / Hypnotics | | | | | 24.0 |
| 5.00 | Other - Specify | | | | | |
| 6.00 | Durable Medical Equipment/Oxygen | | | | | 25.0 |
| 7.00 | Patient Transportation | | 0 | | 0 | 26. |
| 8.00 | Imaging Services | | ŏ | | 0 | 27.0 |
| 9.00 | Labs and Diagnostics | | ň | | 0 0 | 28.0 |
| 0.00 | Medical Supplies | | 0 | | 0 0 | 29.0 |
| 1.00 | Outpatient Services (including F/R Dent) | | 0 | | 9 | 30.0 |
| 2.00 | Radiation Therapy | | o o | | 0 | 31.0 |
| 3.00 | Chemotherapy | | o | | 0 0 | 32.0 |
| 4.00 | Other | | 0 | | - 1 Y | 33.0 |
| | HOSPICE NONREIMBURSABLE SERVICE | | <u></u> | | 0 0 | 34.0 |
| 5.00 | Bereavement Program Costs | T | | | <u> </u> | |
| 6.00 | Volunteer Program Costs | | 0 | | 0 | 35.0 |
| 7.00 | Fundraising | | 0 | | 0 | 36.0 |
| 3.00 | Other Program Costs | | 0 | | 0 | 37.0 |
| €.00 | Total (sum of lines 1 thru 38) | | 0 | | 0 0 | 38.0 |
| • | (Sum of Times I time 30) | 0 | 0 | 373,67 | 4 373,674 | 39.0 |

| 10251 | CCE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (| PAYROLL RELATED) | Provider | CCN: 151310 | Period: | u of Form CMS Worksheet K- | |
|-------|---|--|--|--|----------------------------------|--------------------------------|-------|
| | | | Hospice (| CCN: 151545 | From 01/01/2012 To 12/31/2012 | Date/Time Pr 5/29/2013 8: | epare |
| | | Administrator | | | Hospice I | 3/23/2013 8. | UO ai |
| | | Administrator | Director | Social Services | Supervisors | Nurses | |
| | GENERAL SERVICE COST CENTERS | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| .00 | Capital Related Costs-Bldg and Fixt. | of the parameters are a supplementary of the parameters and the parameters are a supplementary of the parameters and the parameters are a supplementary of the supplementary of the parameters are a supplementary of the para | territorio de la companio del companio de la companio della compan | Control of the Contro | | | - |
| .00 | Capital Related Costs-Movable Equip. | | | | | No. 100 Market and or or other | 1 |
| .00 | Plant Operation and Maintenance | | | | | | 2 |
| .00 | Transportation - Staff | 0 | 0 | | 0 | (| |
| .00 | Voluntoon Commission - Statt | 0 | 0 | | 0 | Ċ | - 1 |
| .00 | Volunteer Service Coordination | 0 | 0 | | 0 | · · | 5 5 |
| .00 | Administrative and General | 0 | 0 | | 0 | Ò | 1 - |
| .00 | INPATIENT CARE SERVICE | | | | | | 4 0 |
| | Inpatient - General Care | 0 | 0 | | 0 0 | | ĵ 7 |
| 00 | Inpatient - Respite Care | 0 | 0 | | 0 0 | | 8 |
| 00 | VISITING SERVICES | | | | | | 4 ° |
| 00 | Physician Services | 0 | 0 | | 0 0 | (| ٠, |
| .00 | Nursing Care | 0 | ol | | o o | - | |
| 00 | Nursing Care-Continuous Home Care | 0 | Ō | | 0 0 | (| 1 |
| .00 | Physical Therapy | 0 | Õ | | 0 0 | C | |
| .00 | Occupational Therapy | 0 | ŏ | | | C | |
| .00 | Speech/ Language Pathology | ő | 0 | | 0 | C | |
| .00 | Medical Social Services | ő | o | | | C | 1 |
| .00 | Spiritual Counseling | ŏ | 0 | | 0 0 | Q | |
| .00 | Dietary Counseling | 0 | 0 | | 9 | 0 | 16 |
| .00 | Counseling - Other | 0 | 0 | | 0 | 0 | 1 |
| .00 | Home Health Aide and Homemaker | 0 | 9 | | 0 | 0 | 18 |
| .00 | HH Aide & Homemaker - Cont. Home Care | 0 | 0 | | 0 | . 0 | 19 |
| .00 | Other | 0 | 0 | | 0 | 0 | 20 |
| | OTHER HOSPICE SERVICE COSTS | U | 0 | | 00 | 0 | 21 |
| .00 | Drugs, Biological and Infusion Therapy | | | | | | 1 |
| .00 | Analgesics | | | | | | 22 |
| .00 | Sedatives / Hypnotics | | | | | | 23 |
| .00 | Other - Specify | | | | | | 24 |
| .00 | Durable Medical Equipment/Oxygen | | 1 | | | | 25 |
| .00 | Patient Transportation | | | | | | 26 |
| .00 | Imaging Services | 0 | 0 | | 0 | 0 | 1 |
| .00 | Labs and Diagnostics | 0 | 0 | | 0 | 0 | 1 |
| .00 | Medical Supplies | 0 | 0 | | 0 | 0 | |
| 00 | Outpatient Services (including E/R Dept.) | 0 | 0 | | 0 0 | ő | |
| 00 | Radiation Therapy | 0 | 0 | | 0 | ŏ | |
| .00 | Chemotherapy | 0 | 0 | 1 | o o | 0 | , |
| | Other | 0 | 0 | | 0 | 0 | 1 |
| | | 0 | 0 | 1 | o o | 0 | |
| 00 | HOSPICE NONREIMBURSABLE SERVICE | | | | <u> </u> | | 34 |
| .00 | Bereavement Program Costs | 0 | 0 | | 0 0 | | 25 |
| 00 | Volunteer Program Costs | 0 | Ö | | | 0 | |
| | Fundraising | 0 | n | | | 0 | |
| .00 | Other Program Costs | 0 | o | Č | - 1 | 0 | |
| .00 | Total (sum of lines 1 thru 38) | o | ő | | | 0 | |

| 10311 | CCE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (| PAYROLL RELATED) | i | CCN: 151310 CN: 151545 | Period: | u of Form CMS-2552- Worksheet K-2 Date/Time Prepared |
|-------|--|--|------------|---------------------------|--|--|
| | | | | | | 5/29/2013 8:08 am |
| | The second secon | Total | Aides | | Hospice I | |
| | | Therapists | Aides | All-Other | Total (1) | |
| | The state of the s | 6.00 | 7.00 | 8.00 | 9.00 | |
| | GENERAL SERVICE COST CENTERS | ners manhare property of the first control of the second second second second second second second second second | | 0.00 | 9.00 | |
| L.00 | Capital Related Costs-Bldg and Fixt. | | | | | |
| 2.00 | Capital Related Costs-Movable Equip. | | | | | 1.0 |
| 3.00 | Plant Operation and Maintenance | | 0 | | | 2.0 |
| .00 | Transportation - Staff | | 0 | | | 3.0 |
| .00 | Volunteer Service Coordination | | 0 | | | 4.0 |
| 6.00 | Administrative and General | | 0 | 163.00 | 762 206 | 5.0 |
| | INPATIENT CARE SERVICE | | | 162,00 | 06 162,006 | 6.0 |
| .00 | Inpatient - General Care | | 0 | | o = ================================== | |
| .00 | Inpatient - Respite Care | 1 | 0 | | 0 | 7.0 |
| | VISITING SERVICES | | UL | | 0 0 | 8.0 |
| .00 | Physician Services | | 0 | | d - | |
| | Nursing Care | | 9 | | 0 | 9.0 |
| 1.00 | Nursing Care-Continuous Home Care | | 0 | | 0 | 10.0 |
| 2.00 | Physical Therapy | 0 | 0 | | 0 | 11.0 |
| 3.00 | Occupational Therapy | | 0 | | 0 | 12.0 |
| 4.00 | Speech/ Language Pathology | 0 | 0 | | 0 | 13.0 |
| 5.00 | Medical Social Services | 0 | 0 | | 0 | 14.0 |
| 6.00 | Spiritual Counseling | | O | | 0 | 15.0 |
| 7.00 | Dietary Counseling | | 0 | | 0 | 16.0 |
| 8.00 | Counseling - Other | | 0 | | 0 | 17.0 |
| 9.00 | Home Health Aide and Homemaker | İ | 0 | | 0 | 18.00 |
| 0.00 | HH Aide & Homemaker - Cont. Home Care | | 0 | | 0 | 19.00 |
| 1.00 | Other | 1 | 0 | | 0 | 20.0 |
| | OTHER HOSPICE SERVICE COSTS | | 0 | | 0 0 | 21.00 |
| 2.00 | Drugs, Biological and Infusion Therapy | | - <u>-</u> | | | |
| 3.00 | Analgesics | | | | | 22.00 |
| 4.00 | Sedatives / Hypnotics | | | | | 23.00 |
| 5.00 | Other - Specify | | | | | 24.0 |
| 5.00 | Durable Medical Equipment/Oxygen | | | | | 25.00 |
| 7.00 | Patient Transportation | | | | | 26.00 |
| | Imaging Services | | 0 | | 0 0 | 27.00 |
| 9.00 | Labs and Diagnostics | | 0 | | o o | 28.00 |
| 0.00 | Medical Supplies | | О | | o ő | 29.00 |
| 1.00 | Outnationt Convices Garage | | 0 | (| 0 | 30.00 |
| 2.00 | Outpatient Services (including E/R Dept.) Radiation Therapy | | 0 | | o o | 31.00 |
| | Chemotherapy | | 0 | (| ol ol | 32.00 |
| | Other | | 0 | | | |
| | | | 0 | | | 33.00 |
| .00 | HOSPICE NONREIMBURSABLE SERVICE | , | | | <u> </u> | 34.00 |
| 00 | Bereavement Program Costs | | 0 | | 0 | |
| 00 | Volunteer Program Costs | | o | | | 35.00 |
| .00 | Fundraising | | o | | | 36.00 |
| .00 | Other Program Costs | | ol | - | | 37.00 |
| .00 | Total (sum of lines 1 thru 38) | o | ŏ | 162,000 | · • | 38.00 |

| | | | Hospice C | CN: 151545 | To 12/31/2012 | Date/Time Pre | epared: |
|-------|---|--|--|----------------------|--------------------------------|--|---------|
| | | | | | Hospice I | 5/29/2013 8:0 | J8 am |
| | | | CAPITAL RE | LATED COST | | | |
| | | NET EXPENSES FOR COST ALLOCATION | BUILDINGS & FIXTURES | MOVABLE EQUIPMENT | PLANT OPERATION & MAINT. | TRANSPORTATION | 1 |
| | GENERAL SERVICE COST CENTERS | . 0 | 1.00 | 2.00 | 3.00 | 4.00 | |
| 1.00 | Capital Related Costs-Bldg and Fixt. | | and the second s | | | - Contraction of the Contraction | |
| 2.00 | Capital Related Costs-Bing and Fixt. Capital Related Costs-Movable Equip. | 0 | 0 | | | | 1.00 |
| 3.00 | Plant Operation and Maintenance | 0 | | | 0 | | 2.00 |
| 4.00 | Transportation staff | 0 | 0 | | 0 | | 3.00 |
| 5.00 | Transportation - Staff | 0 | 0 | | 0 | o | |
| 6.00 | Volunteer Service Coordination | 0 | 0 | | 0 | Ö | 1 |
| 0.00 | Administrative and General | 602,604 | 0 | | 0 | | 7.00 |
| 7.00 | INPATIENT CARE SERVICE | | | | | | 1 0.00 |
| 8.00 | Inpatient - General Care | 0 | 0 | | 0 | 0 | 7.00 |
| 0.00 | Inpatient - Respite Care | 0 | 0 | | 0 | | |
| 0.00 | VISITING SERVICES | ****** | | | | | 0.00 |
| 9.00 | Physician Services | 30,000 | 0 | | 0 0 | 0 | 9.00 |
| 10.00 | Nursing Care | 0 | o | | o o | 0 | |
| 11.00 | Nursing Care-Continuous Home Care | 0 | 0 | | o o | 0 | 1 |
| 12.00 | Physical Therapy | 0 | 0 | | o o | 0 | 1 |
| 13.00 | Occupational Therapy | 0 | ol | | 0 | 0 | |
| 14.00 | Speech/ Language Pathology | 0 | 0 | | o o | - | |
| 15.00 | Medical Social Services | 0 | 0 | | | 0 | |
| 16.00 | Spiritual Counseling | 0 | 0 | | | 0 | |
| 17.00 | Dietary Counseling | 0 | ő | , | 0 | 0 | 0.00 |
| 18.00 | Counseling - Other | 0 | Õ | | | 0 | |
| 19.00 | Home Health Aide and Homemaker | o | ŏ | | | 0 | |
| 20.00 | HH Aide & Homemaker - Cont. Home Care | Ö | o | | [] Y | 0 | |
| 21.00 | Other | Ö | ŏ | | | 0 | |
| | OTHER HOSPICE SERVICE COSTS | <u></u> | | | <u> </u> | 0 | 21.00 |
| 22.00 | Drugs, Biological and Infusion Therapy | 89,357 | 0 | | 0 | | |
| 23.00 | Analgesics | 0 | ő | |] | 0 | |
| 24.00 | Sedatives / Hypnotics | Ö | 0 | | 0 | 0 | 23.00 |
| 25.00 | Other - Specify | 0 | 0 | , | | 0 | 24.00 |
| 26.00 | Durable Medical Equipment/Oxygen | 56,708 | 0 | (| | 0 | 25.00 |
| 27.00 | Patient Transportation | 30,.00 | 0 | (| | 0 | 26.00 |
| 28.00 | Imaging Services | 0 | 0 | (| 9 | 0 | 27.00 |
| 29.00 | Labs and Diagnostics | 0 | 0 | (| 0 | 0 | 28.00 |
| 30.00 | Medical Supplies | 1,015 | 0 | (| 0 | 0 | 29.00 |
| 31.00 | Outpatient Services (including E/R Dept.) | 1,013 | 0 | (| 0 | 0 | 30.00 |
| 32.00 | Radiation Therapy | 0 | U O | (| 0 | 0 | 31.00 |
| 33.00 | Chemotherapy | 0 | 0 | (| 0 | 0 | 32.00 |
| 34.00 | Other | 0 | 0 | C | 1 | 0 | 33.00 |
| Ī | HOSPICE NONREIMBURSABLE SERVICE | 0 | 0 | <u>C</u> | 0 | 0 | 34.00 |
| 35.00 | Bereavement Program Costs | 0 | | | T | | |
| 36.00 | Volunteer Program Costs | 0 | 0 | Q | 1 9 | 0 | 35.00 |
| 37.00 | Fundraising | 0 | 0 | O | 1 | 0 | 36.00 |
| 38.00 | Other Program Costs | 0 | 0 | 0 | 0 | 0 | 37.00 |
| 39.00 | Total (sum of lines 1 thru 38) | 770 684 | 0 | 0 | 0 | 0 | 38.00 |
| • | | 779,684 | O | 0 | 0 | 0 | 39.00 |

| COST | ALLOCATION - HOSPICE GENERAL SERVICE COST | | Provider | CCN: 151310 | Period: | u of Form CMS-2 Worksheet K-4 | 332 |
|------|--|-------------------------|--|---------------------------------------|---|----------------------------------|-----|
| | | | 1 | CCN: 151545 | From 01/01/2012 | Part T | |
| | | | Hospice | CCN: 151545 | To 12/31/2012 | Date/Time Prep 5/29/2013 8:08 | are |
| | The state of the s | making | | | Hospice I | 3/23/2013 0.00 | all |
| | | VOLUNTEER | SUBTOTAL | | VETOTAL (col. 5A | | |
| | | SERVICES COORDINATOR | (cols. 0 - 5) | & GENERAL | ± col. 6) | | |
| | | 5.00 | 5A | 6.00 | 7 | | |
| | GENERAL SERVICE COST CENTERS | 3.00 | | 6.00 | 7.00 | | |
| L.00 | Capital Related Costs-Bldg and Fixt. | | The second secon | · | | | |
| 2.00 | Capital Related Costs-Movable Equip. | | | | | | 1 |
| .00 | Plant Operation and Maintenance | | | | | | 2 |
| .00 | Transportation - Staff | | | | | | 3 |
| .00 | Volunteer Service Coordination | 0 | | | | | 4 |
| .00 | Administrative and General | ő | | 602,60 | \a | | 5 |
| | INPATIENT CARE SERVICE | | 002,00 | 002,00 |]4 | | 6 |
| .00 | Inpatient - General Care | O | (| · · · · · · · · · · · · · · · · · · · | | | |
| .00 | Inpatient - Respite Care | ő | , | 1 | 0 0 | | 7 |
| | VISITING SERVICES | | | 4 | 0 0 | | 8 |
| .00 | Physician Services | 0 | 30,000 | 102 00 | MI | | |
| 0.00 | Nursing Care | 0 | 30,000 | 102,09 | | | 9 |
| 1.00 | Nursing Care-Continuous Home Care | ő | (| | 0 | | 10 |
| 2.00 | Physical Therapy | 0 | | | 0 | | 11 |
| 3.00 | Occupational Therapy | 0 | - | | 0 | 1 | 12 |
| 1.00 | Speech/ Language Pathology | 0 | C | | 0 | | 13 |
| 5.00 | Medical Social Services | 0 | C | <u>'</u> | 0 | 1: | 14 |
| 6.00 | Spiritual Counseling | 0 | C | | 0 |] : | 15 |
| 7.00 | Dietary Counseling | 0 | U | | 0 | : | 16 |
| 3.00 | Counseling - Other | 0 | U | | 0 | | 17 |
| 00.6 | Home Health Aide and Homemaker | | U | | 0 | | 18 |
| 00.0 | HH Aide & Homemaker - Cont. Home Care | 0 | 0 | 1 | 0 | | 19 |
| L.00 | Other | 0 | 0 | ! | 0 | 7 | 20 |
| | OTHER HOSPICE SERVICE COSTS | 0 | 0 | | 0 0 | | 21 |
| 00.1 | Drugs, Biological and Infusion Therapy | T 0 | | r | | | |
| 3.00 | Analgesics | 0 | 89,357 | 304,08 | 2 393,439 | 2 | 22. |
| .00 | Sedatives / Hypnotics | 0 | 0 | | 0 | 2 | 23. |
| .00 | Other - Specify | 0 | 0 | , | 0 | 2 | 24. |
| .00 | Durable Medical Equipment/Oxygen | 0 | 0 | | 0 | 2 | 25. |
| .00 | Patient Transportation | | 56,708 | 192,97 | 249,686 | 2 | 26 |
| .00 | Imaging Services | 0 | 0 | | 0 | 2 | 27. |
| .00 | Labs and Diagnostics | 0 | 0 | (| 0 | 2 | 28. |
| .00 | | | 1 015 | _ (| 0 | 2 | 29. |
| .00 | Outpatient Services (including F/R Dent) | 0 | 1,015 | 3,454 | 4,469 | 3 | 30. |
| .00 | Radiation Therapy | 0 | 0 | (| 0 | | 31. |
| .00 | Chemotherapy | 0 | 0 | (| 0 | | 32. |
| .00 | Other | 0 | 0 | (| - | 1 | 33. |
| | HOSPICE NONREIMBURSABLE SERVICE | 0 | 0 | (| 0 | | 34. |
| .00 | Bereavement Program Costs | | | | | _ | • |
| .00 | Volunteer Program Costs | 0 | 0 | Ó | · | 3 | 35. |
| .00 | Fundraising | 0 | 0 | (| 1 0 | | 36. |
| .00 | Other Program Costs | 0 | 0 | C | 0 | | 37. |
| .00 | Total (sum of lines 1 thru 38) | 0 | 0 | C | o | | 88. |
| | | 0 | 779,684 | | 779,684 | | 9. |

| | | | Hospice | | To 12/31/2012 | | |
|---|--|--------------------------------|--|-------------------------------|---------------------------------------|------------------------|-------|
| *************************************** | | CADTTAL DE | LATED COCT | (pr | Hospice I | | |
| | | CAPITAL RE | LATED COST | | | | |
| | | BUILDINGS & FIXTURES (SQ. FT.) | MOVABLE EQUIPMENT (\$ VALUE) | PLANT OPERATION & MAINT. (SQ. | TRANSPORTATION (MILEAGE) | VOLUNTEER SERVICES | |
| | | | | FT.) | | COORDINATOR (HOURS) | |
| | GENERAL SERVICE COST CENTERS | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 1 |
| 1.00 | Capital Related Costs-Bldg and Fixt. | _ | T | | | | *** |
| 2.00 | Capital Related Costs-Movable Equip. | 0 | l . | | | | 1.00 |
| 3.00 | Plant Operation and Maintenance | 0 | _ | | | | 2.00 |
| 4.00 | Transportation - Staff | 0 | j c | 1 | 0 | | 3.00 |
| 5.00 | Volunteer Service Coordination | 0 | į g | | 0 0 | | 4.00 |
| 6.00 | Administrative and General | 0 | | 1 | 0 | C | 5.00 |
| | INPATIENT CARE SERVICE | 0 | 0 | | 0 | 0 | 6.00 |
| 7.00 | Inpatient - General Care | | or a subject of the last of th | 1 | | | |
| 8.00 | Inpatient - Respite Care | 0 | _ | | 0 | 0 | 7.00 |
| | VISITING SERVICES | 0 | 0 | | 0 | 0 | 8.00 |
| 9.00 | Physician Services | | | | | | 1 |
| | Nursing Care | 0 | 0 | 1 | 0 | 0 | 9.00 |
| 11.00 | | 0 | 0 | 1 | 0 | 0 | 10.00 |
| 12.00 | Physical Therapy | 0 | 0 | 1 | 0 | 0 | 11.00 |
| | Occupational Therapy | 0 | 0 | 1 | 0 | 0 | 12.00 |
| 14.00 | Speech/ Language Pathology | 0 | 0 | 1 | 0 | 0 | 13.00 |
| 15.00 | Medical Social Services | 0 | 0 | 1 | 0 | 0 | 14.00 |
| 16.00 | Spiritual Counseling | 0 | 0 | , | 0 | . 0 | 15.00 |
| 17.00 | Dietary Counseling | 0 | . 0 | , | 0 | 0 | 16.00 |
| 18.00 | Counseling - Other | 0 | 0 | ١ ، | 0 | 0 | 17.00 |
| 19.00 | Home Health Aide and Homemaker | 0 | 0 | | 0 | 0 | 18.00 |
| 20.00 | HH Aide & Homemaker - Cont. Home Care | 0 | 0 | | 1 | 0 | 19.00 |
| 21.00 | Other | 0 | 0 | | 0 | 0 | 20.00 |
| | OTHER HOSPICE SERVICE COSTS | 0 | 0 | L | 0 | 0 | 21.00 |
| 22.00 | Drugs, Biological and Infusion Therapy | | | | | | |
| 23.00 | Analgesics | 0 | 0 | | 0 | 0 | 22.00 |
| | Sedatives / Hypnotics | 0 | 0 | C | 0 | 0 | 23.00 |
| 25.00 | Other - Specify | 0 | 0 | C |] | 0 | 24.00 |
| 26.00 | Durable Medical Equipment/Oxygen | 0 | 0 | O | · · · · · · · · · · · · · · · · · · · | 0 | 25.00 |
| 27.00 | Patient Transportation | 0 | 0 | 0 | 0 | 0 | 26.00 |
| 28.00 | Imaging Services | 0 | 0 | 0 | 0 | 0 | |
| 29.00 | Labs and Diagnostics | 0 | 0 | 0 | 0 | 0 | 28.00 |
| 30.00 | Medical Supplies | 0 | 0 | 0 | 0 | 0 | 29.00 |
| 31.00 | Outpatient Services (including E/R Dept.) | 0 | 0 | 0 | o | 0 | 30.00 |
| 32.00 | Radiation Therapy | 0 | 0 | 0 | 0 | 0 | 31.00 |
| | Chemotherapy | 0 | 0 | 0 | 0 | 0 | 32.00 |
| | Other | 0 | 0 | 0 | 0 | 0 | 33.00 |
| | HOSPICE NONREIMBURSABLE SERVICE | 0 | 0 | 0 | L o | 0 | 34.00 |
| 35.00 | Bereavement Program Costs | | | *** | | | |
| 36.00 | Volunteer Program Costs | 0 | 0 | 0 | 0 | 0 | 35.00 |
| 37.00 | Fundraising | 0 | 0 | 0 | 0 | ő | 36.00 |
| | Other Program Costs | 0 | 0 | 0 | o | ől | 37.00 |
| 39.00 | Cost to be Allocated (per Wkst. K-4, Part I) | 0 | o _i | 0 | 0 | 0 | 38.00 |
| | | U | ام | | - 4 | 9 | |

0.000000

0.000000

0.000000

0.000000

0 39.00

0.000000 40.00

39.00 Cost to be Allocated (per Wkst. K-4, Part I)

40.00 Unit Cost Multiplier

602,604

3.403004

39.00

40.00

40.00 Unit Cost Multiplier

| | | | позртсе | .CN: 151545 | 10 12/31/2012 | Date/Time Pre 5/29/2013 8:0 | pared: |
|----------------|--|---|----------------|-------------|---------------|--------------------------------|--------|
| | The second secon | the development of the process of the state | CARTTAL | | Hospice I | 372372013 0.0 | o an |
| | | | CAPITAL REL | ATED COSTS | | | |
| | Cost Center Description | Hospice Trial | NEW BLDG & | NEW MVBLE | EMPLOYEE | Subtotal | |
| | | Balance (1) | FIXT | EQUIP | BENEFITS | Subtotal | |
| 1.00 | Administrative and General | 0 | 1.00 | 2.00 | 4.00 | 4A | - |
| 2.00 | Inpatient - General Care | | 0 | | 0 13,704 | 13,704 | 1.00 |
| 3.00 | Inpatient - Respite Care | 0 | 0 | | 0 | . 0 | 1 |
| 4.00 | Physician Services | 133 000 | 0 | | 0 | 0 | |
| 5.00 | Nursing Care | 132,090 | 0 | | 0 | 132,090 | 4.00 |
| 6.00 | Nursing Care-Continuous Home Care | 0 | 0 | | 0 | 0 | 5.00 |
| 7.00 | Physical Therapy | 0 | 0 | | 0 | 0 | 6.00 |
| 8.00 | Occupational Therapy | 0 | 0 | | 0 | 0 | 7.00 |
| 9.00 | Speech/ Language Pathology | 0 | o _l | 1 | 0 | 0 | 8.00 |
| 10.00 | Medical Social Services | | U | | 0 | 0 | 9.00 |
| 11.00 | | 0 | 0 | • | 0 | 0 | 10.00 |
| 12.00 | | 0 | 0 | | 0 | 0 | 11.00 |
| 13.00 | | 0 | 0 | | | 0 | 12.00 |
| 14.00 | | 0 | 0 | { | 0 | 0 | 13.00 |
| 15.00 | HH Aide & Homemaker - Cont. Home Care | 0 | 0 | 9 | | 0 | 14.00 |
| 16.00 | Other | 0 | 0 | (| 0 | 0 | 15.00 |
| 17.00 | Drugs, Biological and Infusion Therapy | 393,439 | 0 | (| | 0 | 16.00 |
| 18.00 | Analgesics | 333, 433 | 0 | (| 0 | 393,439 | 17.00 |
| 19.00 | Sedatives / Hypnotics | 0 | 0 | (| 0 | 0 | 18.00 |
| 20.00 | Other - Specify | 0 | 0 | (| 0 | 0 | 19.00 |
| 21.00 | Durable Medical Equipment/Oxygen | 249,686 | 0 | (| 1 | 0 | 20.00 |
| 22.00 | Patient Transportation | 0 | 0 | (| 1 | 249,686 | |
| 23.00 | Imaging Services | ő | 0 | (| 1 | 0 | 22.00 |
| 24.00 | Labs and Diagnostics | ŏ | o | (| 0 | 0 | 23.00 |
| 25.00 | Medical Supplies | 4,469 | 0 | | | 0 | 24.00 |
| 26.00 | Outpatient Services (including E/R Dept.) | 0 | 0 | | 0 | 4,469 | 25.00 |
| 27.00 | Radiation Therapy | o | ٥ | 0 | 0 | 0 | 26.00 |
| 28.00 29.00 | Chemotherapy | 0 | ŏ | 0 | 0 | 0 | 27.00 |
| 30.00 | Other | o | ő | 0 | 0 | 0 | 28.00 |
| | Bereavement Program Costs | o | ŏ | 0 | 0 | 0 | 29.00 |
| | Volunteer Program Costs | o | o | 0 | 0 | 0 | 30.00 |
| 33.00 | Fundraising | 0 | Ö | 0 | 0 | 0 | 31.00 |
| 34.00 | Other Program Costs | o | o | 0 | ı Vı | 0 | 32.00 |
| 35.00 | Total (sum of lines 1 thru 33) (2) | 779,684 | O | 0 | 13,704 | | 33.00 |
| 55.00 | Unit Cost Multiplier (see instructions) | | 7 | O | 13,704 | | 34.00 |
| | | | , | | 1 | 0.000000 | 35.00 |

Health Financial Systems WABASH COUNTY HOSPITAL In Lieu of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS Provider CCN: 151310 Period: Worksheet K-5

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151310
Hospice CCN: 151545
Period:
From 01/01/2012
To 12/31/2012
Worksheet K-5
Part I
Date/Time Prepared:
5/29/2013 8:08 am

| | | | Hospice (| CCN: 151545 | | 12 Part 1 12 Date/Time Pre 5/29/2013 8:0 | epared: 08 am |
|-------|---|----------------|-----------|-------------|---------------|--|------------------|
| | Cost Center Description | 7 | | | Hospice I | | |
| | and and south peron | OTHER | BUSINESS | MAINTENANCE | & OPERATION O | F LAUNDRY & | T |
| | | ADMINISTRATIVE | OFFICE | REPAIRS | PLANT | LINEN SERVICE | |
| | | AND GENERAL | | | | | 1 |
| 1.00 | Administrative and General | 5.01 | 5.02 | 6.00 | 7.00 | 8.00 | - |
| 2.00 | Inpatient - General Care | 1,765 | 692 | | 0 | 0 0 | 1.00 |
| 3.00 | Inpatient - Respite Care | 0 | 0 | | 0 | 0 0 | 1.00 |
| 4.00 | Physician Services | 0 | 0 | | 0 | 0 0 | 1 |
| 5.00 | Nursing Care | 17,014 | 6,622 | | o | 0 0 | 3.00 |
| 6.00 | Nursing Care-Continuous Home Care | 0 | 0 | | 0 | 0 0 | |
| 7.00 | Physical Therapy | 0 | 0 | | 0 | 0 0 | 3.00 |
| 8.00 | Occupational Therapy | 0 | 0 | | 0 | 0 0 | 0.00 |
| 9.00 | Speech/ Language Pathology | 0 | 0 | | 0 | 0 0 | |
| 10.00 | Medical Social Services | 0 | 0 | | 0 | 0 0 | 9.00 |
| 11.00 | Spiritual Counseling | 0 | 0 | | 0 | 0 0 | |
| 12.00 | Dietary Counseling | 0 | 0 | | 0 | 0 0 | 20.00 |
| 13.00 | | 0 | 0 | | o | 0 0 | 12.00 |
| 14.00 | Home Health Aide and Homemaker | 0 | 0 | | 0 | 0 0 | 13.00 |
| 15.00 | HH Aide & Homemaker - Cont. Home Care | O | 0 | | 0 | 0 0 | 14.00 |
| 16.00 | Other | 0 | 0 | | 0 | 0 0 | 15.00 |
| 17.00 | | 0 | 0 | | 0 | 0 0 | 16.00 |
| 18.00 | Analgesics | 50,677 | 19,723 | | 0 | 0 0 | 17.00 |
| 19.00 | Sedatives / Hypnotics | O | 0 | | 0 | 0 | 18.00 |
| 20.00 | Other - Specify | 0 | 0 | | 0 | o ŏ | 19.00 |
| 21.00 | Durable Medical Equipment/Oxygen | 22.161 | 0 | | 0 | o ŏ | 20.00 |
| 22.00 | Patient Transportation | 32,161 | 12,517 | | 0 | ol ő | 21.00 |
| 23.00 | Imaging Services | U | 0 | | 0 | 0 0 | 22.00 |
| 24.00 | Labs and Diagnostics | U | 0 | | 0 | o o | 23.00 |
| 25.00 | Medical Supplies | 0 | 0 | | o | 0 0 | 24.00 |
| 26.00 | Outpatient Services (including E/R Dent) | 576 | 224 | • | 0 | 0 0 | 25.00 |
| 27.00 | Radiation Therapy | U | 0 | (| 0 | 0 | 26.00 |
| 28.00 | Chemotherapy | U | 0 | (| 0 | o o | 27.00 |
| 29.00 | Other | ٥ | 0 | (| 0 | 0 | 28.00 |
| 30.00 | | U O | U | (| 0 | _1 1 | 29.00 |
| 31.00 | Volunteer Program Costs | U O | 0 | (| 0 | 0 | 30.00 |
| 32.00 | Fundraising | U | O | (| 0 | 0 | 31.00 |
| 33.00 | Other Program Costs | U | O | (| 0 | 0 | 32.00 |
| 34.00 | Total (sum of lines 1 thru 33) (2) | 102 102 | 0 | (| 0 | · I | 33.00 |
| 35.00 | Unit Cost Multiplier (see instructions) | 102,193 | 39,778 | (| 0 | | 34.00 |
| | t to the mistractions) | 1 | | | | | 35.00 |
| | | | | | | | |

 Health Financial Systems
 WABASH

 ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
 WABASH COUNTY HOSPITAL Period: Worksheet K-5 From 01/01/2012 Part I Provider CCN: 151310

| | | | Hospice (| CCN: 151545 | | Part I Date/Time Pre 5/29/2013 8:0 | pared: 8 am |
|--|---|--------------|-----------|-------------|--|--|----------------|
| William Control of Con | Cost Center Description | HOUSEKEEPING | DIETARY | CAFETERIA | Hospice I NURSING ADMINISTRATION | CENTRAL SERVICES & SUPPLY | |
| 1.00 | Administrative and General | 9.00 | 10.00 | 11.00 | 13.00 | 14.00 | |
| 2.00 | Inpatient - General Care | 0 | 0 | . | 0 0 | 0 | 1.00 |
| 3.00 | Inpatient - Respite Care | 0 | 0 | | 0 0 | 0 | 2.00 |
| 4.00 | Physician Services | 0 | 0, | 1 | 0 | ol | 3.00 |
| 5.00 | Nursing Care | 0 | 0 | | 0 0 | 0 | |
| 6.00 | Nursing Care-Continuous Home Care | 0 | 01 | 1 | 0 | o l | 5.00 |
| 7.00 | Physical Therapy | 0 | 0 | | 0 0 | 0 | 6.00 |
| 8.00 | Occupational Therapy | 0 | 0 | 1 | 0 | ő | 7.00 |
| 9.00 | Speech/ Language Pathology | 0 | 0 | ĺ | 0 0 | o l | 8.00 |
| 10.00 | Medical Social Services | 0 | 0 | | 0 0 | ő | 9.00 |
| 11.00 | | 0 | 0 | 1 | 0 | ő | 10.00 |
| 12.00 | | 0 | 0 | i | 0 0 | ő | 11.00 |
| 13.00 | | 0 | 0 | 1 | 0 0 | 0 | 12.00 |
| 14.00 | | 0 | 0 | I | 0 0 | o | 13.00 |
| 15.00 | Home Health Aide and Homemaker | 0 | 0 | 1 | 0 0 | 0 | 14.00 |
| 16.00 | HH Aide & Homemaker - Cont. Home Care | O | 0 | l | o o | 0 | 15.00 |
| 17.00 | | 0 | 0 | ľ | 0 0 | 0 | 16.00 |
| 18.00 | Drugs, Biological and Infusion Therapy | o | 0 | i | o o | 0 | 17.00 |
| | | 0 | 0 | ı | Ö | 0 | 18.00 |
| 73.00 | | 0 | 0 | , | 0 0 | * | 19.00 |
| | Other - Specify | 0 | 0 | i | ő | 0 | |
| 21.00 | | 0 | o | , | 0 0 | - 1 | 20.00 |
| 22.00 | | 0 | 0 | | | 0 | 21.00 |
| 23.00 | Imaging Services | ol | ol | | | | 22.00 |
| 24.00 | Labs and Diagnostics | 0 | 0 | | 0 0 | I | 23.00 |
| | (Supplies | o | o | | | | 24.00 |
| 26.00 | Outpatient Services (including E/R Dept.) | 0 | ō | | | | 25.00 |
| | Radiation Therapy | ol | ō | | | i | 26.00 |
| | | 0 | ő | | 0 | | 27.00 |
| | Other | 0 | ő | | | | 28.00 |
| 30.00 | Bereavement Program Costs | 0 | ŏ | | | | 29.00 |
| 31.00 | Volunteer Program Costs | 0 | ŏ | , | | | 30.00 |
| | Fundraising | 0 | 0 | • | 0 | | 31.00 |
| 33.00 | Other Program Costs | ol | ő | • | 0 | | 32.00 |
| 34.00 | Total (sum of lines 1 thru 33) (2) | Ŏ | ő | , | 0 | | 33.00 |
| 35.00 | Unit Cost Multiplier (see instructions) | Ĭ | ٧ | , | 이 | | 34.00 |
| | • | 1 | I | | | | 35.00 |

| Health Financial Systems ALLOCATION OF GENERAL SERVICE COSTS | WABASH COUNTY HO | 7 | | Lieu of Form CMS-2552-10 |
|--|-------------------------|----------------------|---------|--------------------------|
| TENER DERVICE COSTS | TO HOSPICE COST CENTERS | Provider CCN: 151310 | Period: | Worksheet κ−5 |

| | | | | CCN: 151545 | To 12/31/2012 Hospice I | Date/Time Pre 5/29/2013 8:0 | pared: 8 am |
|--------------|---|----------|---------------------------------|---------------------------|---|--------------------------------|----------------|
| | Cost Center Description | PHARMACY | MEDICAL RECORDS & LIBRARY | Subtotal (cols. 4A-23) | Intern & Residents Cost & Post Stepdown Adjustments | Subtotal (cols. 24 ± 25) | |
| 1 00 | | 15.00 | 16.00 | 24.00 | 25.00 | 26.00 | |
| 1.00 2.00 | Administrative and General | 0 | 0 | 16,161 | | 20.00 | 1.00 |
| 3.00 | Inpatient - General Care | 0 | 0 | Ź | 0 | 0 | |
| 4.00 | Inpatient ~ Respite Care | 0 | 0 | C | | ő | |
| 5.00 | Physician Services | 0 | 0 | 155,726 | 0 | 155,726 | |
| 5.00 | Nursing Care | 0 | ol | · c | أم | 133,720 | |
| 7.00 | Nursing Care-Continuous Home Care Physical Therapy | 0 | 0 | C | 0 | 0 | |
| 3.00 | Occupational Theorem | 0 | 0 | 0 | 0 | 0 | 1 |
| 9.00 | Occupational Therapy | 0 | 0 | 0 | o o | 0 | 8.00 |
| 10.00 | Speech/ Language Pathology Medical Social Services | 0 | 0 | 0 | ol | Ö | 9.00 |
| | Spiritual Counseling | 0 | 0 | 0 | 0 | ő | |
| 2 00 | Dietary Counseling | 0 | 0 | 0 | o | 0 | |
| 3 00 | Counseling - Other | 0 | 0 | 0 | 0 | Ö | |
| 4.00 | | 0 | 0 | 0 | o | 0 | 13.00 |
| .5.00 | HH Aide & Homemaker - Cont. Home Care | 0 | 0 | 0 | 0 | ő | 14.00 |
| 6.00 | Other | 0 | 0 | 0 | o | 0 | 15.00 |
| | Drugs, Biological and Infusion Therapy | 0 | 0 | 0 | o | ō | 16.00 |
| 8.00 | Analgesics | 0 | 0 | 463,839 | 0 | 463,839 | |
| 9.00 | Sedatives / Hypnotics | 0 | 0 | 0 | 0 | 0 | 18.00 |
| 0.00 | Other - Specify | 0 | O | 0 | 0 | 0 | 19.00 |
| 1.00 | Durable Medical Equipment/Oxygen | 0 | 0 | 0 | 0 | 0 | 20.00 |
| 2.00 | Patient Transportation | 0 | 0 | 294,364 | 0 | 294,364 | |
| 3.00 | Imaging Services | 0 | 0 | 0 | 0 | 0 | 22.00 |
| 4.00 | Labs and Diagnostics | 0 | 0 | 0 | 0 | 0 | 23.00 |
| 5.00 | Medical Supplies | 0 | 0 | 0 | 0 | 0 | 24.00 |
| 6.00 | Outpatient Services (including E/R Dent) | 0 | 0 | 5,269 | 0 | 5,269 | 25.00 |
| 7.00 | Radiation Therapy | | 0 | 0 | 0 | 0 | 26.00 |
| 8.00 | Chemotherapy | 0 | 0 | 0 | 0 | . 0 | 27.00 |
| 9.00 | Other | | 0 | 0 | 0 | 0 | 28.00 |
| 0.00 | Bereavement Program Costs | 0 | 0 | 0 | 0 | 0 | 29.00 |
| 1.00 | Volunteer Program Costs | | 0 | 0 | 0 | 0 | 30.00 |
| 2.00 | Fundraising | 0 | 0 | o | 0 | 0 | 31.00 |
| 3.00 | Other Program Costs | 0 | 0 | 0 | 0 | 0 | 32.00 |
| 1.00 | Total (sum of lines 1 thru 33) (2) | 0 | 0 | 935,359 | 0 | 0 | 33.00 |
| | Unit Cost Multiplier (see instructions) | | | | | 935,359 | 34.00 |

OCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151310 | Period: From 01/01/2012 | To 12/31/2012 | Date/Time Prepared: 5/29/2013 8:08 am

| | | | | Hospice CCI | :N: 1: | 51545 | То | 12/31/2012 | Date/Time 5/29/2013 | Prepared: 8:08 am |
|-------|---|---|---|-------------|--------|-------|-----------------|------------|--|----------------------|
| | Cock Country | ration of the second second second second second second second second second second second second second second | | | | | | Hospice I | -/==/2025 | 0.00 um |
| | Cost Center Description | Allocated | | l Hospice | | | | | ************************************** | |
| | | Hospice A&G | | s (cols. | | | | | | |
| | | (See Part II) | | ± 27) | | | | | | |
| 1.00 | Administrative and General | 27.00 | - | 28.00 | | | Strandon Survey | | | |
| 2.00 | Inpatient - General Care | | | | | | | | | 1.00 |
| 3.00 | Inpatient - Respite Care | 0 | | 0 | | | | | | 2.00 |
| 4.00 | Physician Services | 0 | | 0 | | | | | | 3.00 |
| 5.00 | Nursing Care | 2,738 | | 158,464 | | | | | | 4.00 |
| 6.00 | Nursing Care-Continuous Home Care | 0 | | 0 | | | | | | 5.00 |
| 7.00 | Physical Therapy | 0 | | 0 | | | | | | 6.00 |
| 8.00 | Occupational Therapy | 0 | | 0 | | | | | | 7.00 |
| 9.00 | Speech/ Language Pathology | 0 | | 0 | | | | | | 8.00 |
| | Medical Social Services | 0 | | 0 | | | | | | 9.00 |
| 11.00 | Spiritual Counseling | 0 | | O | | | | | | 10.00 |
| 12.00 | Dietary Counseling | 0 | | 0 | | | | | | 11.00 |
| 13.00 | Counseling - Other | 0 | | 0 | | | | | | 12.00 |
| 14.00 | Home Health Aide and Homemaker | 0 | | 0 | | | | | | 13.00 |
| 15.00 | HH Aide & Homemaker - Cont. Home Care | 0 | | 0 | | | | | | 14.00 |
| 16.00 | Other | 0 | | 0 | | | | | | 15.00 |
| | Drugs, Biological and Infusion Therapy | 0 154 | | 0 | | | | | | 16.00 |
| 18.00 | Analgesics | 8,154 | | 471,993 | | | | | | 17.00 |
| | Sedatives / Hypnotics | 0 | | 0 | | | | | | 18.00 |
| 20.00 | Other - Specify | 0 | | 0 | | | | | | 19.00 |
| 21.00 | Durable Medical Equipment/Oxygen | 5 176 | | 0 | | | | | | 20.00 |
| 22.00 | Patient Transportation | 5,176 | | 299,540 | | | | | | 21.00 |
| 23.00 | Imaging Services | 0 | | 0 | | | | | | 22.00 |
| 24.00 | Labs and Diagnostics | 0 | | 0 | | | | | | 23.00 |
| | Medical Supplies | 93 | | 0 | | | | | | 24.00 |
| | Outpatient Services (including E/R Dept.) | 93 | | 5,362 | | | | | | 25.00 |
| 27.00 | Radiation Therapy | 0 | | 0 | | | | | | 26.00 |
| 28.00 | Chemotherapy | 0 | | 0 | | | | | | 27.00 |
| 29.00 | Other | 0 | | 0 | | | | | | 28.00 |
| 30.00 | Bereavement Program Costs | 0 | | 0 | | | | | | 29.00 |
| 31.00 | Volunteer Program Costs | 0 | | O | | | | | | 30.00 |
| 32.00 | Fundraising | 0 | | O O | | | | | | 31.00 |
| 33.00 | Other Program Costs | | | U | | | | | | 32.00 |
| 34.00 | Total (sum of lines 1 thru 33) (2) | ١ | | 035 350 | | | | | | 33.00 |
| 35.00 | Unit Cost Multiplier (see instructions) | 0.017582 | | 935,359 | | | | | | 34.00 |
| | 1 1-1 (-10 10 00 000 000 000) | 0.01/382 | | İ | | | | | | 35.00 |

Health Financial Systems

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

STATISTICAL BASIS

WABASH COUNTY HOSPITAL

Provider CCN: 151310
Hospice CCN: 151345

Hospice CCN: 151545

In Lieu of Form CMS-2552-10

Worksheet K-5
Part II
Date/Time Prepared:
5/29/2013 8:08 am

| | | | | | | 5/29/2013 8:0 | 8 am |
|------|---|--------------|------------|-----------|----------------|----------------|------|
| - | | CAPITAL RELA | TED COCTE | | Hospice I | | · |
| | | CAFTIAL RELA | TIED COSTS | | | | |
| | Cost Center Description . | NEW BLDG & | NEW MVBLE | EMPLOYEE | Reconciliation | OTHER | |
| | | FIXT | EQUIP | BENEFITS | | ADMINISTRATIVE | |
| | | (SQUARE | (DOLLAR | (GROSS | | AND GENERAL | |
| | | FEET) | VALUE) | SALARIES) | | (ACCUM. COST) | l |
| 00 | Administrative and General | 1.00 | 2.00 | 4.00 | 5A.01 | 5.01 | |
| .00 | Inpatient - General Care | 0 | 0 | 373,674 | 0 | 13,704 | 1. |
| .00 | Inpatient - Respite Care | 0 | 0 | (| 0 | 0 | 2. |
| .00 | Physician Services | 0 | 0 | C | 0 | 0 | 3. |
| .00 | Nursing Care | 0 | 0 | C | 0 | 132,090 | 4. |
| .00 | Nursing Care-Continuous Home Care | 0 | 0 | C | 0 | 0 | 5. |
| .00 | Physical Therapy | 0 | 0 | C | 0 | 0 | 6. |
| .00 | Occupational Therapy | 0 | 0 | C | 0 | 0 | 7. |
| .00 | Speech/ Language Pathology | 0 | 0 | C | 0 | 0 | 8. |
| 0.00 | Medical Social Services | 0 | 0 | C | 0 | 0 | 9. |
| 1.00 | | 0 | 0 | 0 | 0 | 0 | 10. |
| 2.00 | Dietary Counseling | 0 | 0 | 0 | 0 | 0 | 11. |
| 3 00 | Counseling - Other | 0 | 0 | 0 | 0 | 0 | 12. |
| 1.00 | Home Health Aide and Homemaker | 0 | 0 | 0 | 0 | 0 | 13. |
| 5.00 | HH Aide & Homemaker - Cont. Home Care | 0 | 0 | 0 | 0 | 0 | 14. |
| 6.00 | Other | 0 | 0 | 0 | 0 | 0 | 15. |
| | Drugs, Biological and Infusion Therapy | 0 | 0 | 0 | 0 | 0 | 16. |
| 8.00 | Analgesics | 0 | 0 | 0 | 0 | 393,439 | 17. |
| 9.00 | Sedatives / Hypnotics | 0 | 0 | 0 | 0 | 0 | 18. |
| 0.00 | Other - Specify | 0 | 0 | 0 | 0 | 0 | 19. |
| L.00 | Durable Medical Equipment/Oxygen | 0 | 0 | 0 | 0 | 0 | 20. |
| 2.00 | Patient Transportation | 0 | 0 | 0 | 0 | 249,686 | 21. |
| 3.00 | Imaging Services | 0 | 0 | 0 | 0 | 0 | 22. |
| 1.00 | Labs and Diagnostics | 0 | 0 | 0 | 0 | 0 | 23. |
| .00 | Medical Supplies | 0 | 0 | 0 | 0 | 0 | 24. |
| 5.00 | Outpatient Services (including E/R Dept.) | 0 | 0 | 0 | 0 | 4,469 | 25. |
| .00 | Radiation Therapy | 0 | 0 | 0 | 0 | 0 | 26. |
| .00 | Chemotherapy | 0 | 0 | 0 | 0 | 0 | 27. |
| | Other | 0 | 0 | 0 | 0 | 0 | 28. |
| | Bereavement Program Costs | 0 | 0 | 0 | 0 | 0 | 29. |
| .00 | Volunteer Program Costs | | 0 | 0 | 0 | 0 | 30.0 |
| .00 | Fundraising | | 0 | 0 | 0 | 0 | 31. |
| .00 | Other Program Costs | 0 | 0 | 0 | 0 | 0 | 32. |
| .00 | Total (sum of lines 1 thru 33) (2) | 0 | 0 | 0 | 0 | 0 | 33. |
| .00 | Total cost to be allocated | 0 | 0 | 373,674 | | 793,388 | 34.0 |
| .00 | Unit Cost Multiplier (see instructions) | 0 000000 | 0 | 13,704 | | 102,193 | |
| | imitaly (See Miscraetions) | 0.000000 | 0.000000 | 0.036674 | | 0.128806 | 36.0 |

Health Financial Systems WABASH COUNTY HOSPITAL In Lieu of Form CMS-2552-10 ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS Provider CCN: 151310 Period: Worksheet K-5 STATISTICAL BASIS From 01/01/2012

Part II
Date/Time Prepared: Hospice CCN: 151545 To 12/31/2012 5/29/2013 8:08 am Hospice I Cost Center Description BUSINESS MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPING OFFICE REPAIRS **PLANT** LINEN SERVICE (SQUARE (ACCUM. COST) (SQUARE (SQUARE (POUNDS OF FEET) FEET) FEET) LAUNDRY) 5.02 6.00 7.00 9.00 8.00 1.00 Administrative and General 13,806 0 0 1.00 2.00 Inpatient - General Care 0 0 0 3.00 Inpatient - Respite Care 0 2.00 0 0 3.00 4.00 Physician Services 0 132,090 0 4.00 5.00 Nursing Care 0 0 6.00 0 5.00 Nursing Care-Continuous Home Care 0 0 6.00 7.00 Physical Therapy ol 0 0 0 7.00 8.00 Occupational Therapy 0 0 n 9.00 Speech/ Language Pathology 8.00 0 0 0 9.00 10.00 Medical Social Services 0 0 10.00 11.00 Spiritual Counseling 0 0 12.00 Dietary Counseling 0 11.00 0 0 0 12.00 13.00 Counseling - Other 0 0 0 13.00 14.00 Home Health Aide and Homemaker 0 0 0 15.00 HH Aide & Homemaker - Cont. Home Care 14.00 O 0 15.00 16.00 Other 0 16.00 17.00 Drugs, Biological and Infusion Therapy 393,439 0 0 0 17.00 18.00 Analgesics 0 0 0 19.00 0 18.00 Sedatives / Hypnotics 0 0 20.00 Other - Specify 19.00 0 0 0 20.00 21.00 | Durable Medical Equipment/Oxygen 249,686 Patient Transportation 0 21.00 22.00 0 0 0 23.00 | Imaging Services 0 22.00 0 0 0 24.00 23.00 Labs and Diagnostics 0 0 0 0 24.00 25.00 Medical Supplies 4,469 0 0 0 26.00 Outpatient Services (including E/R Dept.) 25.00 0 0 0 26.00 27.00 **Radiation Therapy** 0 0 0 0 28.00 27.00 Chemotherapy 0 0 0 29.00 Other 28.00 0 0 0 30.00 Bereavement Program Costs 29.00 0 0 0 31.00 | Volunteer Program Costs 30.00 0 0 0 32.00 Fundraising 0 31.00 0 0 0 33.00 Other Program Costs 0 32.00 0 0 0 Total (sum of lines 1 thru 33) (2) 0 34.00 33.00 793,490 0 0 0 35.00 Total cost to be allocated 0 34.00

39,778

0.000000

0.000000

0.000000

0.050130

0 35.00

0.000000 36.00

36.00 Unit Cost Multiplier (see instructions)

Health Financial Systems WABASH COUNTY HOSPITAL In Lieu of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS Provider CCN: 151310 Period:
STATISTICAL BASIS Provider CCN: 151310 Period:
FFORM 01/01/2012 Part II.

| | STICAL BASIS | | Hospice | CCN: 151545 | From 01/01/2012 To 12/31/2012 | Part II Date/Time Pre | epared: |
|---------------------|--|------------------------------|----------------------|---|---|---------------------------------|---------|
| was family states a | Cost Center Description | DIETARY (MEALS SERVED) | CAFETERIA (HOURS) | NURSING ADMINISTRATIO (DIRECT NRSING HRS) | HOSPICE I CENTRAL ON SERVICES & SUPPLY (COSTED REQUIS.) | PHARMACY (COSTED REQUIS.) | |
| 1.00 | | 10.00 | 11.00 | 13.00 | 14.00 | 15.00 | |
| 2.00 | Administrative and General | 0 | 0 | A STATE OF STREET, S. C. CO., S. C. C. C. C. C. C. C. C. C. C. C. C. C. | 0 0 | 0 | 1.00 |
| 3.00 | Inpatient - General Care Inpatient - Respite Care | 0 | 0 | | 0 0 | 0 | |
| 4.00 | Physician Services | 0 | 0 | | o o | 0 | |
| 5.00 | Nursing Care | 0 | 0 | · | 0 0 | 0 | 3.00 |
| 6.00 | Nursing Care-Continuous Home Care | 0 | 0 | | o o | ő | 100 |
| 7.00 | Physical Therapy | 0 | 0 | | 0 | 0 | 3.00 |
| 8.00 | Occupational Therapy | 0 | 0 | | 0 | 0 | 0.00 |
| 9.00 | Speech/ Language Pathology | 0 | 0 | | 0 0 | 0 | |
| | Medical Social Services | 0 | 0 | | 0 0 | 0 | 1 0.00 |
| 11.00 | Spiritual Counseling | 0 | 0 | | 0 0 | 0 | 1 |
| 12.00 | Dietary Counseling | 0 | 0 | | 0 0 | 0 | |
| 13.00 | Counseling - Other | 0 | 0 | , | 0 | 0 | |
| 14.00 | Home Health Aide and Homemaker | 0 | 0 | | 0 0 | 0 | 1 |
| 15.00 | HH Aide & Homemaker - Cont. Home Care | 0 | 0 | | 0 | 0 | |
| 16.00 | Other | 0 | 0 | ' | 0 | 0 | |
| 17.00 | Drugs, Biological and Infusion Therapy | 0 | 0 | 1 | 0 0 | 0 | |
| 18.00 | Analgesics | 0 | 0 | (| 0 | 0 | 17.00 |
| 19.00 | Sedatives / Hypnotics | | 0 | • | 0 | 0 | 18.00 |
| 20.00 | Other - Specify | 0 | 0 | (| 0 | 0 | 19.00 |
| 21.00 | Durable Medical Equipment/Oxygen | 0 | 0 | | 0 | 0 | 20.00 |
| 22.00 | Patient Transportation | | 0 | (| 0 | 0 | 21.00 |
| 23.00 | Imaging Services | 0 | 0 | (| 0 | 0 | 22.00 |
| 24.00 | Labs and Diagnostics | 0 | 0 | (| 9 | 0 | 23.00 |
| 25.00 | Medical Supplies | 0 | 0 | (| 0 | 0 | 24.00 |
| 26.00 | Outpatient Services (including E/R Dept.) | 0 | 0 | (| ٧ | 0 | 25.00 |
| 27.00 | Radiation Therapy | o | 0 | (| | 0 | 26.00 |
| | Chemotherapy | 0 | 0 | (| | 0 | 27.00 |
| | Other | 0 | 0 | (| | 0 | 28.00 |
| 30.00 | Bereavement Program Costs | 0 | 0 | (| | 0 | 29.00 |
| 31.00 | Volunteer Program Costs | ٥ | 0 | (| | 0 | 30.00 |
| 32.00 | Fundraising | o | 0 | (| | 0 | 31.00 |
| 33.00 | Other Program Costs | ŏ | 0 | | | 0 | 32.00 |
| 34.00 | Total (sum of lines 1 thru 33) (2) | 0 | 0 | | | 0 | 33.00 |
| 35.00 | Total cost to be allocated | 0 | 0 | 0 | 0 | 0 | 34.00 |
| 36.00 | Unit Cost Multiplier (see instructions) | 0.000000 | 0.000000 | 0.000000 | 0.000000 | 0 | 35.00 |
| | | | 0.000000 | 0.000000 | 0.000000 | 0.000000 | 36.00 |

| TATIS | ATION OF GENERAL SERVICE COSTS TO HOSPICE COS STICAL BASIS | I CENTERS | Provider CCN: 15131 Hospice CCN: 1515 | 0 Period: From 01/01/2012 | worksheet K-5 Part II Date/Time Prepa 5/29/2013 8:08 | ared |
|-------|---|---|--|--|---|--------------|
| | Cook Contan Day | | | Hospice I | 3/23/2013 0.00 | _a111 |
| | Cost Center Description | MEDICAL RECORDS & LIBRARY (GROSS REV) 16.00 | | West dealers and the second se | | ~~~~ |
| .00 | Administrative and General | 10.00 | determinents on the same contribute and the contribute of the same of the contribute | - | | |
| .00 | Inpatient - General Care | o | | | | 1.0 |
| .00 | Inpatient - Respite Care | 0 | | | | 2.0 |
| .00 | Physician Services | o | | | 1 | 3.0 |
| .00 | Nursing Care | ŏ | | | | 4.0 |
| .00 | Nursing Care-Continuous Home Care | 0 | | | | 5.0 |
| .00 | Physical Therapy | ő | | | | 6.0 |
| .00 | Occupational Therapy | o | | | | 7.0 |
| .00 | Speech/ Language Pathology | 0 | | | | 8.0 |
|).00 | Medical Social Services | ŏ | | | | 9.0 |
| 00 | Spiritual Counseling | o | | | | 10.0 |
| .00 | Dietary Counseling | o | | | | 11.(|
| .00 | Counseling - Other | o | | | | 12.0 |
| .00 | Home Health Aide and Homemaker | o | | | | 13.(|
| - 00 | HH Aide & Homemaker - Cont. Home Care | 0 | | | 1 | 14.(|
| | Other | 0 | | | | 15.(16.(|
| , uu | Drugs, Biological and Infusion Therapy Analgesics | 0 | | | | 16.0 17.(|
| 00 | Sedatives / Hypnotics | 0 | | | | 18. |
| 00 | Other - Specify | 0 | | | | 19. |
| 00 | Durable Medical Equipment/Oxygen | 0 | | | | 20.0 |
| .00 | Patient Transportation | 0 | | | | 21.0 |
| .00 | Imaging Services | 0 | | | | 22.0 |
| .00 | Labs and Diagnostics | 0 | | | | 23.0 |
| .00 | Medical Supplies | 0 | | | 1 1 | 24.(|
| .00 | Outpatient Services (including E/R Dept.) | 0 | | | | 25.0 |
| .00 | Radiation Therapy | 0 | | | | 26. |
| | Chemotherapy | 0 | | | | 7.0 |
| | Other | 0 | | | | 8.0 |
| .00 | Bereavement Program Costs | 0 | | | 29 | 9.0 |
| .00 | Volunteer Program Costs | | | | 30 | 0.0 |
| .00 | Fundraising | 0 | | | | 1.0 |
| .00 | Other Program Costs | 0 | | | 32 | 2.0 |
| .00 | Total (sum of lines 1 thru 33) (2) | 0 | | | 33 | 3.0 |
| .00 | Total cost to be allocated | 0 | | | 34 | 4.0 |
| 00 1 | Unit Cost Multiplier (see instructions) | 0.000000 | | | 1 25 | 5.0 |

| | h Financial Systems | WABASH COUNTY HO | SPITAL_ | | In Lie | u of Form CMS- | 2552-10 |
|--|--|------------------|---|-------------------------------|---|---|---|
| COMPO | TATION OF TOTAL HOSPICE SHARED COSTS | | | CCN: 151310 CCN: 151545 | Period: From 01/01/2012 | Worksheet K-5 | pared: |
| Venezione della di consumenta | Cost Center Description | Wkst I, | col. 11 line | Ratio | Hospice I ge Total Hospice Charges (Provider Records) | Hospice Shared Ancillary Costs (cols. 1 x 2) | |
| | ANCILLARY SERVICE COST CENTERS | | 0 | 1.00 | 2.00 | 3.00 | |
| 1.00 2.00 3.00 4.00 5.00 6.00 6.01 7.00 8.00 9.00 10.00 11.00 | PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY DRUGS CHARGED TO PATIENTS DURABLE MEDICAL EQUIP-RENTED LABORATORY BLOOD LABORATORY MEDICAL SUPPLIES CHARGED TO PATIENTS OTHER OUTPATIENT SERVICE COST CENTER RADIOLOGY-THERAPEUTIC OTHER ANCILLARY SERVICE COST CENTERS | | 66.00 67.00 68.00 73.00 96.00 60.01 71.00 93.00 55.00 | 0.20246 0.23474 0.48655 | 67 0 19 0 | 0 0 0 | 1.00 2.00 3.00 4.00 5.00 6.00 6.01 7.00 8.00 9.00 10.00 |

| | n Financial Systems WABASH COUNT | TY HOSPITAL | | In Lie | eu of Form CMS- | 2552-10 |
|--|--|-------------|-------------|----------------------------|--------------------------------|---|
| CALCU | LATION OF HOSPICE PER DIEM COST | | CCN: 151310 | Period: From 01/01/2012 | Worksheet K-6 | |
| | | Hospice | CCN: 151545 | To 12/31/2012 | Date/Time Pre 5/29/2013 8:0 | pared: 8 am |
| | A Section of the sect | | | Hospice I | | |
| | | Title XVIII | Title XIX | | Total | |
| 1.00 | Total cost (see instructions) | 1.00 | 2.00 | 3.00 | 4.00 | |
| 2.00 | Total Unduplicated Days (Worksheet S-9, column 6, line 5) | | | | 935,359 | |
| 3.00 | Average cost per diem (line 1 divided by line 2) | | | | 7,413 | |
| 4.00 | Upduplicated Medicare Days (Worksheet S-9, column 1, line 5) | 7,41 | 3 | | 126.18 | 3.00 4.00 |
| 5.00 6.00 | Aggregate Medicare cost (line 3 time line 4) Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5) | 935,372 | | o | | 5.00 6.00 |
| 7.00 8.00 9.00 10.00 11.00 12.00 13.00 | Aggregate Medicaid cost (line 3 time line 60) Upduplicated SNF Days (worksheet S-9, column 3, line 5) Aggregate SNF cost (line 3 time line 8) Unduplicated NF Days (worksheet S-9, column 4, line 5) Aggregate NF cost (line 3 times line 10) Other Unduplicated days (worksheet S-9, column 5, line 5) Aggregate cost for other days (line 3 times line 12) | (| | 0 0 0 | | 7.00 8.00 9.00 10.00 11.00 12.00 |